

**IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA**

**IN RE: DIET DRUGS
(Phentermine/Fenfluramine/Dexfenfluramine)
PRODUCTS LIABILITY LITIGATION**

MDL Docket No. 1203

**This Document Relates to:
SHEILA BROWN, et al., v. AMERICAN HOME
PRODUCTS CORPORATION**

Civil Action No. 99-20593

**SUPPLEMENT TO CLASS COUNSEL’S MOTION: (A) TO STRIKE
THE SEVENTH AMENDMENT OBJECTIONS OF ANGELA DUFFY,
FRANK DEJULIUS AND CINDY PATTISON FOR LACK OF STANDING
AND (B) FOR LEAVE TO TAKE DEPOSITIONS OF
SEVENTH AMENDMENT OBJECTOR, DEBRA RHEA**

I. INTRODUCTION

On November 24, 2004, Class Counsel filed Class Counsel’s Motion: (A) To Strike the Seventh Amendment Objections of Angela Duffy, Frank DeJulius and Cindy Pattison for Lack of Standing and (B) For Leave to Take the Deposition of Seventh Amendment Objector, Debra Rhea. (hereinafter referred to as the “Motion”).

In that Motion, Class Counsel described their knowledge of the status of Cindy Pattison as an alleged Class Member according to the information contained in the AHP Settlement Trust (the “Trust”) database as of November 23, 2004, and attached as Exhibit “A” to the Motion a printout of such information in a Claim Inquiry report¹.

Similarly, that Motion described Class Counsel’s knowledge of the status of Angela S. Duffy and Debra K. Rhea as alleged Class Members according to the information contained in the Trust

¹The Claim Inquiry Report is a document that summarizes information in the Trust database in a form created by Class Counsel for ease of review.

database as of November 23, 2004, and attached as Exhibits “B” and “C”, respectively, to the Motion a printout of such information in Claim Inquiry reports.²

It has been brought to the attention of Class Counsel that the Trust database as of November 23, 2004 did not accurately reflect the alleged Class Member status of these three objectors, and accordingly, Class Counsel file this supplement to their Motion to provide the Court with the additional information learned. It will be noted, however, that the additional information does not alter the points made in Class Counsel’s Motion, that objectors Cindy Pattison, Angela Duffy and Frank DeJulius do not have standing to object to the Seventh Amendment, and accordingly, their objections should be stricken.³

II. SUPPLEMENTAL INFORMATION

Updated Information About Cindy Pattison

As noted by the original Motion, Class Counsel queried the Trust database for information about objector Cindy Pattison, the person on whose behalf attorney Lawrence Schonbrun has filed an objection to the Seventh Amendment. Mr. Schonbrun’s pleading identified his client as “Cindy Pattison”, and the Trust database identified such an individual under DDR #3211554. The information contained in the Trust database on November 23, 2004 for that individual is reflected in Exhibit “A” to the Motion. The Trust database for “Cindy Pattison”, DDR #3211554 did not

²Class Counsel could not identify any information in the Trust database regarding the alleged Class Member status of objector Frank DeJulius as of November 23, 2004, and as of this filing, still have not been able to identify any information in the Trust database for this individual.

³In essence, the relief that Class Counsel’s Motion seeks remains appropriate, even though the facts are somewhat different than first thought. The different facts do not alter the fact that these three objectors do not have standing to object to the Seventh Amendment.

indicate that there was a duplicate registration or different Claim Number assigned to that individual. All that the Trust database showed was that there were miscellaneous filings made on April 20, 2000, and October 25, 2000, that were scanned into the Trust database for that individual, which were copies of pleadings filed in connection with that individual's objections to the original settlement, and further showed that no Pink, Blue or Orange 1 Form had been filed for that individual.

Moreover, the objection filed by Cindy Pattison to the Seventh Amendment did not indicate her DDR number, nor that she had filed any forms with the Trust, or that she even had received any benefits, or had been tested by echocardiogram. In fact, her objection explicitly admitted that she had NOT had an echocardiogram, which fact, by definition precludes her from having standing to object to the Seventh Amendment. This is because in order for a Class Member to be either a Category One or Category Two Class Member pursuant to the terms of the Seventh Amendment, that Class Member necessarily would have had to have been tested by echocardiogram in order to have filed a Green Form for possible Category One benefits, or to have filed a Gray Form for possible Category Two benefits.

Since Cindy Pattison does not allege that she has been tested by echocardiogram, and in fact her objection admits that she never had an echocardiogram, she can not possibly have standing to object to the Seventh Amendment, as she cannot satisfy the predicate condition to standing, which is having had a timely echocardiogram.

Nevertheless, on December 3, 2004, Class Counsel was advised by counsel for Wyeth, that upon further investigation into the Trust database concerning the status of Cindy Pattison, Counsel for Wyeth determined that the information that Cindy Pattison had not registered with the Trust

might not be accurate. Accordingly, on that date, Class Counsel again queried the Trust database, and found that for “Cindy Pattison”, under DDR #3211554 (the DDR number previously identified by the database as having been assigned to her), that the entries had changed from how they were recorded on November 23, 2004, and there was now a notation that there was a Duplicate Claim for this individual. The Duplicate Claim notation appears to have been entered into the Trust database on November 30, 2004, several days after the filing of Class Counsel’s Motion. A copy of the Claim Inquiry for Cindy Pattison for December 3, 2004, revealing the new entry of “Duplicate Claim” entered on November 30, 2004, is attached hereto as Exhibit “1”.⁴

Accordingly, Class Counsel queried the Trust database further, to determine the link to the “Duplicate Claim” notation that now appeared for Cindy Pattison. Class Counsel identified a “Cynthia Pattison”, also represented by Mr. Schonbrun, and assigned DDR #8011193. The results of this query are reflected by the Claim Inquiry attached hereto as Exhibit “2”. The information contained in the Trust database under this DDR number on December 3, 2004, seems to have merged information contained in the Trust database under Cindy Pattison, DDR #3211554 into the information for Cynthia Pattison, under DDR #8011193.⁵

⁴Presumably, upon the Trust receiving Class Counsel’s Motion, the Trust examined its database for accuracy, and identified the error that for Cindy Pattison, the database did not reveal the existence of her Duplicate Claim. The Trust did not advise Class Counsel of this error in the database, nor did the Trust advise Class Counsel that the “Duplicate Claim” entry had been made.

⁵Class Counsel also queried the Trust database under DDR #8011193 as of the back-up data provided to Class Counsel on November 22, 2004. The results of this query are reflected on the Claim Inquiry report attached hereto as Exhibit “3”. This Claim Inquiry report shows a “print date” of Friday, December 03, 2004, but it reflects the status for that Claim as of November 22, 2004. It does NOT show the merging of the Duplicate Claim Information from DDR #3211554, as it does when that DDR number was queried on December 3, 2004. Thus, it seems clear that the Trust did not identify the Duplicate Claim status until after Class Counsel’s Motion, and the correction to the Trust database seemingly was made on November 30, 2004.

For example, as of November 23, 2004, the Trust database for Cindy Pattison, DDR #3211554 indicated two "MISC" filings for April 20, 2000 and for October 25, 2000, and also, that there had been no filing of a Pink/Blue/Orange 1 Form with a deficiency date of 2/12/2003.

However, the database information for Cindy Pattison, DDR #3211554 as of December 3, 2004, shows that such entries seemed to have been purged from that DDR number, and instead the notation of a Duplicate Claim has been entered.

The entries for Cynthia Pattison, DDR #8011193 contain the purged information from Cindy Pattison, DDR #3211554, and also shows that the deficiency for NO Pink/Blue/Orange 1 was cancelled on November 30, 2004, the same date that the Duplicate Claim entry was entered.

However, aside from the inaccuracy of the Trust's database for Cindy Pattison, DDR #3211554 on November 23, 2004, assuming that the database is correct as of December 3, 2004, it confirms what Mr. Schonbrun has said about his client, Cindy (Cynthia) Pattison. The Trust database does not show that she has had an echocardiogram. In fact, what the Trust database seems to show is that she was qualified to receive a free echocardiogram in the Trust's Screening Program, was notified of her qualification for that benefit, but that she appears to never have availed herself of the opportunity to obtain the free echocardiogram.

Nevertheless, since under DDR #8011193, the Trust database shows that Cynthia Pattison had filed a Blue Form, Class Counsel has reviewed the Blue Form filing. It also shows that Ms. Pattison had not had an echocardiogram as of the date of the filing of her Blue Form. *See*, Blue Form for Cynthia Pattison for DDR #8011193, attached hereto as Exhibits "4" and "5".⁶

⁶Two copies of the same Blue Form are attached, as it appears it was submitted to the Trust twice, once with a receipt date of April 15, 2002, and once with a receipt date of June 3, 2003.

Accordingly, although the Trust's database did not accurately reflect the Duplicate Claim status for Cindy Pattison on November 23, 2004, and the Trust apparently corrected that error on November 30, 2004, the fact remains that Cindy (Cynthia) Pattison does not have standing to object to the Seventh Amendment. In her counsel's pleading, she admits not having had an echocardiogram, and the Trust database confirms that there has not been a filing of an echocardiogram on her behalf with the Trust. In the absence of her having had an echocardiogram, by definition she cannot be a member of either Category One nor Category Two of the Seventh Amendment.⁷

Updated Information About Angels S. Duffy

Class Counsel has also investigated the status of objector, Angela S. Duffy, in an effort to verify the accuracy of the Trust database information that Class Counsel relied on in filing the Motion on November 24, 2004. Class Counsel's Motion included at Exhibit "B" thereto, the Claim Inquiry Report for Angela S. Duffy, DDR #2753499. An inquiry under that DDR number on December 3, 2004, shows no changes, or updated information for that alleged Class Member under that DDR number. *See*, Exhibit "6" hereto, December 3, 2004 Claim Inquiry report for Angela S. Duffy under DDR# 2753499.

⁷The Trust database does show, however, that Cynthia Pattison has been paid her drug refund benefit of \$ 500.00. So, under the terms of the Settlement Agreement, she is a Subclass 1(b) Class Member. A Subclass 1 (b) Class Member is entitled to a drug refund, and because such individual ingested the Diet Drugs for 61 days or more and had not been diagnosed as suffering from FDA positive heart valve regurgitation, such a Class Member was also entitled to a free echocardiogram in the Trust's Screening Program. The results of that free echocardiogram would then determine if the Class member was entitled to additional benefits, such as the cash/medical services benefit as a result of a diagnosis of FDA positive heart valve regurgitation, or the ability to file a Green Form to make a claim for Matrix Compensation Benefits. However, it seems Ms. Pattison waived her rights to additional benefits by not accepting the free echocardiogram benefit offered by the Settlement Trust, and not having obtained a private echocardiogram within the Screening Period.

Nevertheless, Class Counsel determined to further investigate this alleged Class Member's status in the Trust database, and in doing so, found an entry for Angela S. Duffy under DDR #8140581. *See*, Exhibit "7" hereto, December 3, 2004 Claim Inquiry report for Angela S. Duffy under DDR #8140581. The entries under this DDR number appear to be for the same person, even though there is no indication in the Trust database that there is a duplicate claim for Angela S. Duffy. The address, date of birth and phone number for the Angela S. Duffy under DDR #2753499 and under DDR #8140581 match. It is fair to assume that this is not merely coincidental, but that in fact, there is only one Angela S. Duffy who lives at 1002 Lyle Lane, Lagrange, KY, 40031, with a phone number of (502) 222-3589 and a date of birth of 7/7/1973.⁸

Nevertheless, the information in the Trust database for Angela S. Duffy under DDR #8140581 does not change the point of Class Counsel's Motion, that this Class Member has no standing to object to the Seventh Amendment, because she has apparently never had an echocardiogram. The Trust database information for this individual does not show that she ever filed a Gray or a Green Form. The database information does not show the filing of an echocardiogram report. And, in the Blue Form she filed, she checked the box to Question 11 that she had not had an echocardiogram. *See*, copy of Blue Form attached hereto as Exhibit "8".

This answer is an admission that she does not have standing to object to the Seventh Amendment. This is because for a Class Member to be effected by the Seventh Amendment, the Class Member had to have had an echocardiogram either with the Trust Screening Program, or a privately obtained echocardiogram by the end of the Screening period that showed the Class

⁸Class Counsel does not know why the Trust has not merged the data or why it has not eliminated the duplicate DDR # for this Class Member. Clearly, the Trust can take such action, as it created a Duplicate Claim entry for Class Member Pattison.

Member to be diagnosed with either at least mild mitral regurgitation or mild aortic regurgitation. Without such a timely diagnosis, the Class Member will not be effected by the Seventh Amendment, and will not have standing to object to its provisions.

In fact, what the database shows is that this Class Member, like Class Member Pattison, received a drug refund benefit, and was offered a free echocardiogram in the Trust's Screening Program, but that she never availed herself of that benefit. Thus, she like Class Member Pattison is a Subclass 1 (b) Class Member under the Settlement Agreement, but has no standing to object to the Seventh Amendment because she does not meet the criteria to be either a Category One or Category Two Class Member under the terms of the Seventh Amendment.

So, although the failure of the Trust database to have coded Angela S. Duffy as having been assigned two DDR numbers, the fact remains that Angela S. Duffy has not demonstrated that she has standing to object to the Seventh Amendment.

Updated Statement Concerning Frank DeJulius

As for objector Frank DeJulius, that individual still does not appear in the Trust database according to the best of Class Counsel's knowledge. Thus, there is no new information to provide to the Court regarding this alleged Class Member possibly having standing to object to the Seventh Amendment. This alleged Class Member still does not appear in the Trust database as of December 3, 2004, and accordingly, does not have standing to object to the Seventh Amendment, for the reasons articulated in the Motion. This alleged Class Member's objection should be stricken for lack of standing.

Updated Statement Concerning Debra K. Rhea

Finally, Class Counsel also ran another query of the Trust database for Class member Debra

K. Rhea on December 3, 2004. A copy of the Claim Inquiry report for that query is attached hereto as Exhibit "9". The results of the query are identical to the results for the query that Class Counsel ran on November 23, 2004, a copy of which was attached to the Motion as Exhibit "C".

Thus, for this Class Member, the relief that Class Counsel sought in the Motion remains the same, which is the request to take the deposition of Debra K. Rhea.

III. CONCLUSION

For the foregoing reasons in Class Counsel's Motion and in this Supplement, the objections to the Seventh Amendment of alleged Class Members Cindy (Cynthia) Pattison, Angela S. Duffy, and Frank DeJulius should be stricken for lack of standing. Class Counsel continue to seek the deposition of Class Member Debra K. Rhea in connection with her objection to the Seventh Amendment.

Respectfully submitted,

A handwritten signature in black ink, appearing to be "A. Levin", written over a horizontal line.

Arnold Levin, Esquire
Michael D. Fishbein, Esquire
Laurence S. Berman, Esquire
LEVIN, FISHBEIN, SEDRAN & BERMAN
510 Walnut Street, Suite 500
Philadelphia, PA 19106
*LIAISON COUNSEL IN MDL 1203, CO-LEAD
COUNSEL IN MDL 1203 & CLASS COUNSEL IN
BROWN, C.A. NO. 99-20593*

EXHIBIT “1”

Claim Inquiry: PATTISON, CINDY - DDR # 3211554

DDR #	DDR Name	PIN	SSN	DoB	Admin Hold
3211554	PATTISON, CINDY	91481			<u>DUPLICATE CLAIMS</u>
		Day Phone:			
		NightPhone:			
Attorney Information:					
Type	Attorney	Firm		City	State
Claim Payments					
Type	Check #	Date	Amount	Status	Clear Date
General Deficiencies:					
Code	Deficiency		Def Date	Cancel Date	Notice Date
			Strikes		
Green Deficiencies:					
			Def Date	Cancel Date	Notice Date
			Strikes		
Green Form Data					
Physician		Phys City	State	GF Mx	GFA Mx
		Audit Mx	Res		
Gray Data					
Status	Physician	Echo Date	MR	AR	
Document History					
Doc Code	Document Type	Rec Date	Post Mark	Box #	DCN
Claim Activities:					
Activity		Date	Cancel Date		
DP_HOLD	Duplicate Claim	11/30/2004			

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EXHIBIT “2”

Claim Inquiry: PATTISON, CYNTHIA - DDR # 8011193

DDR #	DDR Name	PIN	SSN	DoB	Admin Hold
8011193	PATTISON, CYNTHIA 705 SANTA CRUZ LN FOSTER CITY, CA 94404		559-68-7453 Day Phone: (065) 036-3411 NightPhone: (650) 578-9244	3/30/1950	

Attorney Information:

Type	Attorney	Firm	City	State
Inactive	X	X		
Primary	LAWRENCE W. SCHONBRUN	LAWRENCE W. SCHONBRUN	BERKLEY	CA

Claim Payments

Type	Check #	Date	Amount	Status	Clear Date
DRUG	2130438	1/27/2003	\$500.00	V	
DRUG	2321631	6/27/2003	\$500.00		7/21/2003

General Deficiencies:

Code	Deficiency	Def Date	Cancel Date	Notice Date	Strikes
055	FORM - NO PINK/BLUE/ORANGE1	2/12/2003	11/30/2004		

Green Deficiencies:

Def Date Cancel Date Notice Date Strikes

Green Form Data

Physician	Phys City	State	GF Mx	GFA Mx	Audit Mx	Res
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Gray Data

Status	Physician	Echo Date	MR	AR
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Document History

Doc Code	Document Type	Rec Date	Post Mark	Box #	DCN
34	PHARMACY RECORDS	6/3/2003	5/28/2003		16153418011193
38	MEDICAL RECORDS AUTHORIZATION	6/3/2003	5/28/2003		16153818011193
42	NEW BLUE	6/3/2003	5/28/2003		16154218011193
61	Echo Followup Letter	11/12/2002	10/25/2002		14126118011193
58	ELIGIBILITY FOR SCREENING PROGRAM/PRESC. COST REF	7/17/2002	7/17/2002		12945818011193
34	PHARMACY RECORDS	4/15/2002			12013418011193
42	NEW BLUE	4/15/2002			12014218011193
10	MISC.	10/25/2000			00299100001023
10	MISC.	4/20/2000			00111100004003

Claim Activities:

Activity	Date	Cancel Date
QA_DRUG	SCHEDULED FOR DRUG QA REVIEW	8/25/2003
RV_ECHO	SCHEDULED FOR ECHO REVIEW	8/25/2003
QA_ECHO	SCHEDULED FOR ECHO QA REVIEW	8/25/2003
RV_CMS	SCHEDULED FOR CMS REVIEW	8/25/2003
QA_CMS	SCHEDULED FOR CMS QA REVIEW	8/25/2003
RV_DRUG	SCHEDULED FOR DRUG REVIEW	8/8/2003
PY_DRUG	BENEFIT PAID -- DRUG	6/27/2003
SB_DRUG	SCHEDULED FOR BENEFIT -- DRUG	6/2/2003 6/27/2003
FEFCLMLD	Final Echo follow up mailed - claimant copy	3/21/2003
FEFATMLD	Final Echo follow up mailed - attorney copy	3/21/2003 3/22/2003
PY_DRUG	BENEFIT PAID -- DRUG	1/27/2003 6/2/2003
SB_DRUG	SCHEDULED FOR BENEFIT -- DRUG	1/26/2003 1/27/2003
RM_HOLD	Returned Mail HOLD	11/12/2002 11/13/2002

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EFLMLD	ECHO Follow Up Letter Mailed	10/25/2002	
RM_HOLD	Returned Mail HOLD	8/5/2002	8/5/2002
CCN_LTR	CCN Matching letter sent	7/24/2002	
PY_ESCR	SENT TO CRAWFORD FOR ECHO	7/8/2002	
SB_ESCR	SCHEDULED FOR BENEFIT -- ECHO	7/3/2002	7/3/2002
WY_ESCR	CLAIM AT WYETH ACCESS -- ECHO	6/25/2002	7/3/2002
WR_ESCR	READY FOR WYETH ACCESS -- ESCR	6/14/2002	6/14/2002
ESCR_ERR	ESCR_ERR	6/14/2002	
WR_DRUG	READY FOR WYETH ACCESS -- DRUG	6/14/2002	6/14/2002
WY_DRUG	CLAIM AT WYETH ACCESS -- DRUG	6/14/2002	1/26/2003
QA_Drug	SCHEDULED FOR DRUG QA REVIEW	6/11/2002	6/14/2002
RV_Drug	SCHEDULED FOR DRUG REVIEW	6/6/2002	6/14/2002
BL1_REC	INITIAL BLUE INFORMATION IMPORTED FROM INDIA	5/9/2002	

EXHIBIT “3”

Claim Inquiry: PATTISON, CYNTHIA - DDR # 8011193

DDR #	DDR Name	PIN	SSN	DoB	Admin Hold
8011193	PATTISON, CYNTHIA 705 SANTA CRUZ LN FOSTER CITY, CA 94404		559-68-7453 Day Phone: (065) 036-3411 NightPhone: (650) 578-9244	3/30/1950	

Attorney Information:

Type	Attorney	Firm	City	State
Inactive	X	X		
Primary	LAWRENCE W. SCHONBRUN	LAWRENCE W. SCHONBRUN	BERKLEY	CA

Claim Payments

Type	Check #	Date	Amount	Status	Clear Date
DRUG	2130438	1/27/2003	\$500.00	V	
DRUG	2321631	6/27/2003	\$500.00		7/21/2003

General Deficiencies:

Code	Deficiency	Def Date	Cancel Date	Notice Date	Strikes
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Green Deficiencies:

Def Date	Cancel Date	Notice Date	Strikes
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Green Form Data

Physician	Phys City	State	GF Mx	GFA Mx	Audit Mx	Res
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Gray Data

Status	Physician	Echo Date	MR	AR
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Document History

Doc Code	Document Type	Rec Date	Post Mark	Box #	DCN
34	PHARMACY RECORDS	6/3/2003	5/28/2003		16153418011193
38	MEDICAL RECORDS AUTHORIZATION	6/3/2003	5/28/2003		16153818011193
42	NEW BLUE	6/3/2003	5/28/2003		16154218011193
61	Echo Followup Letter	11/12/2002	10/25/2002		14126118011193
58	ELIGIBILITY FOR SCREENING PROGRAM/PRESC. COST REF	7/17/2002	7/17/2002		12945818011193
34	PHARMACY RECORDS	4/15/2002			12013418011193
42	NEW BLUE	4/15/2002			12014218011193

Claim Activities:

Activity	Date	Cancel Date
QA_DRUG	SCHEDULED FOR DRUG QA REVIEW	8/25/2003
RV_ECHO	SCHEDULED FOR ECHO REVIEW	8/25/2003
QA_ECHO	SCHEDULED FOR ECHO QA REVIEW	8/25/2003
RV_CMS	SCHEDULED FOR CMS REVIEW	8/25/2003
QA_CMS	SCHEDULED FOR CMS QA REVIEW	8/25/2003
RV_DRUG	SCHEDULED FOR DRUG REVIEW	8/8/2003
PY_DRUG	BENEFIT PAID -- DRUG	6/27/2003
SB_DRUG	SCHEDULED FOR BENEFIT -- DRUG	6/2/2003 6/27/2003
FEFCLMLD	Final Echo follow up mailed - claimant copy	3/21/2003
FEFATMLD	Final Echo follow up mailed - attorney copy	3/21/2003 3/22/2003
PY_DRUG	BENEFIT PAID -- DRUG	1/27/2003 6/2/2003
SB_DRUG	SCHEDULED FOR BENEFIT -- DRUG	1/26/2003 1/27/2003
RM_HOLD	Returned Mail HOLD	11/12/2002 11/13/2002
EFLMLD	ECHO Follow Up Letter Mailed	10/25/2002
RM_HOLD	Returned Mail HOLD	8/5/2002 8/5/2002

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As of Trust backup - 11/22/04

CCN_LTR	CCN Matching letter sent	7/24/2002	
PY_ESCR	SENT TO CRAWFORD FOR ECHO	7/8/2002	
SB_ESCR	SCHEDULED FOR BENEFIT -- ECHO	7/3/2002	7/3/2002
WY_ESCR	CLAIM AT WYETH ACCESS -- ECHO	6/25/2002	7/3/2002
WR_ESCR	READY FOR WYETH ACCESS -- ESCR	6/14/2002	6/14/2002
ESCR_ERR	ESCR_ERR	6/14/2002	
WR_DRUG	READY FOR WYETH ACCESS -- DRUG	6/14/2002	6/14/2002
WY_DRUG	CLAIM AT WYETH ACCESS -- DRUG	6/14/2002	1/26/2003
QA_Drug	SCHEDULED FOR DRUG QA REVIEW	6/11/2002	6/14/2002
RV_Drug	SCHEDULED FOR DRUG REVIEW	6/6/2002	6/14/2002
BL1_REC	INITIAL BLUE INFORMATION IMPORTED FROM INDIA	5/9/2002	

EXHIBIT “4”

BLUE FORM

Diet Drug Settlement With American Home Products Corporation

NOTICE: You do not need to complete this form if you have already submitted either a completed and signed PINK FORM under the Accelerated Implementation Option or a completed and signed BLUE FORM.

This BLUE FORM is to be used by any Class Member who wants to register for Settlement Benefits and must be mailed to the AHP Settlement Trust postmarked no later than August 1, 2002, for certain benefits and no later than May 3, 2003, for other benefits. To understand these deadlines fully, see the Chart on page 12 of this form, the *Official Notice of Final Judicial Approval*, or the Settlement Agreement.

Print or type all responses. By completing this BLUE FORM you are registering for benefits under the Settlement. If you have retained a lawyer regarding your use of diet drugs, you should consult him or her about your options under the Settlement.

Do not detach or separate bound Claim Forms.

1. Complete the following information for the Diet Drug Recipient (the person who used the diet drugs).

Cynthia Scott Trenton
(First Name) (Middle Initial) (Last Name)

Cynthia
(List all other names that you use or have used during the last ten years)

1745 Santa Cecilia
(Street Address)

Franklin City CO 17404
(City) (State) (Zip Code)

(610) 261-1911 (610) 518-1721
(Daytime Area Code & Phone Number) (Evening Area Code & Phone Number)

WBC@AHS.com
(E-mail Address, if any)

07/01/1950 1509-1851-1741913
(Birth Date MM/DD/YYYY) (Social Security Number)

Gender: ☒ Female ☐ Male

Remove the BLUE FORM label from the Notice Package, affix here and fill out all information above.

Mail this form to:
AHP Settlement Trust
P.O. Box 7939
Philadelphia, PA 19101

For assistance, call 1-800-386-2070
Or access <http://www.settlementdietdrugs.com>

BLUE FORM - 1



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APR 15 2002

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2. Are you completing this questionnaire as the "Representative Claimant" (i.e., estate, administrator, other legal representative, heir or beneficiary of a Diet Drug Recipient)?

☒ No (skip to Question #3) ☐ Yes (complete the following)

(First Name) (Middle Initial) (Last Name)

(Street Address)

(City) (State) (Zip Code)

() _____
(Daytime Area Code & Phone Number) (Evening Area Code & Phone Number)

(E-mail Address, if any)

(Your relationship to the Diet Drug Recipient)

If you are a Representative Claimant, attach a copy of the order or document appointing you the Diet Drug Recipient's legal representative.

If you are representing a deceased's estate, attach an official copy of the death certificate along with a copy of any letters of administration, probate or surrogate certificate. State the date of death:

Date of Death: _____
(MM/DD/YYYY)

3. Are you completing this questionnaire as a "Derivative Claimant" (i.e., a spouse, child, dependent, parent, other relative or "significant other" of a Diet Drug Recipient)?

☒ No (go to Question #5) ☐ Yes (go to Question #4)

- 4.a. Provide the following information concerning each "Derivative Claimant." (If there is more than one, check here ☐ and either copy this section of the form or use another copy of this form to provide the information. Include that paper with this form.)

(First Name) (Middle Initial) (Last Name)

(Street Address)

(City) (State) (Zip Code)

() _____
(Daytime Area Code & Phone Number) (Evening Area Code & Phone Number)

(E-mail Address, if any)

(Birth Date MM/DD/YYYY) (Social Security Number)

BLUE FORM - 2



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b. Specify the relationship of the Derivative Claimant to the Diet Drug Recipient.

- ☐ Spouse ☐ Dependent, specify _____
☐ Parent ☐ Other relative, specify _____
☐ Child ☐ Significant other, specify _____

c. If you selected "Spouse" above, what is the current status of the relationship of the Derivative Claimant to the Diet Drug Recipient?

- ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Date of the marriage: ____/____/____
(MM/DD/YYYY)

d. If you, the Derivative Claimant, are currently estranged from the Diet Drug Recipient, state the date of separation and/or divorce.

Date: ____/____/____
(MM/DD/YYYY)

(Provide evidence of the date of separation or divorce, i.e., separation agreement or divorce decree).

e. Identify the basis on which the Derivative Claimant is claiming "derivative" benefits.

- ☐ Loss of Consortium/Per Quod (e.g., loss of marital services and relationship)
☐ Loss of Support
☐ Loss of Service
☐ Other, explain: _____

NOTE: Each Claimant (including Representative and/or Derivative Claimants) must sign the Declaration under Penalty of Perjury on page 7 of this BLUE FORM (making copies if necessary) and submit it with this form.

5. Are you represented by any lawyer in connection with this Claim?

- ☒ Yes ☐ No

6. If you answered "Yes" to Question #5, provide the following information:

(Law Firm Name)

(Attorney's First Name) _____
(Middle Initial) (Last Name)

(Street Address)

(City) _____
(State) _____
(Zip Code)

(Daytime Area Code & Phone Number) _____
(Fax Area Code & Number)

(E-mail Address, if any)

BLUE FORM - 3



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NOTE: If you are completing this questionnaire as a Representative or Derivative Claimant, the following questions using the term "You" refer to the "Diet Drug Recipient."¹

7. State whether you were prescribed and took the following Diet Drugs:

Pondimin® (Fenfluramine) ☒ Yes ☐ No

Redux™ (Dexfenfluramine) ☒ Yes ☐ No

8. Indicate by checking the appropriate box below the total period of time that you took Pondimin® and/or Redux™:

(If you took both drugs, add together the period of time you used each drug to determine the total period of use.)

☐ 60 days or less ☒ 61 days or more

9. State the total number of days that you used each of the following diet drugs:

Pondimin® _____ days

Redux™ 448 days

You bear the ultimate responsibility for providing records to substantiate the total number of days you used Pondimin® and/or Redux™.

10. You must provide the information requested below.

a. If the diet drug (Pondimin® and/or Redux™) was dispensed by a pharmacy, identify the pharmacy name, address and telephone number.

COSTCO PHARMACY #147
(Pharmacy Name)

1901 METRO CENTER BLVD
(Street Address)

FOSTER CITY CA 94404
(City) (State) (Zip Code)

(650) 286-0759
(Area Code and Phone Number)

[If there was more than one pharmacy that dispensed the diet drugs Pondimin® and/or Redux™, make a copy or copies of this page and provide the information for each such pharmacy and include those additional sheets with this form.]

Provide a copy of the pharmacy prescription dispensing records (e.g., prescription printouts, pharmacy records, prescription forms) from each pharmacy, which should include the medication name, quantity, frequency, dosage and number of refills prescribed, prescribing physician's name, assigned prescription number, original fill date and each subsequent refill date.

OR

¹ The "Diet Drug Recipient" is the person who took Pondimin®, Redux™, and/or the drug combination commonly known as "Fen-Phen."



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- b. If the diet drug (Pondimin® and/or Redux®) was dispensed directly by a physician or weight loss clinic, or the pharmacy record(s) is unobtainable, state the name of each physician who prescribed the diet drug, and the address and telephone number of that physician:

 (First Name of Prescribing Physician) (Middle Initial) (Last Name)

 (Name of Weight Loss Clinic, if applicable)

 (Street Address)

 (City) (State) (Zip Code)

 (Area Code & Telephone Number)

[If there was more than one physician or weight loss clinic that prescribed and/or dispensed the diet drugs Pondimin® and/or Redux®, make a copy or copies of this page and provide the information for each such physician or weight loss clinic and include those additional sheets with this form.]

Provide a copy of the medical record(s) reflecting the prescription and/or dispensing of the diet drugs. This must include records that identify the Diet Drug Recipient, the diet drug name, the date(s) prescribed, the dosage and duration for which the drug was prescribed or dispensed.

If, and only if, the pharmacy record(s) or prescribing physician's medical record(s) are unobtainable, check here ☐ and have your prescribing physician or dispensing pharmacist complete the attached Declaration of Prescribing Physician or Dispensing Pharmacy.

11. Have you had an Echocardiogram² after you first started using diet drugs?

☐ Yes ☒ No

If yes, state the date(s) of each Echocardiogram(s) and the name and address of each physician who performed the Echocardiogram or reported the results to you.

Date	Name of Physician/Clinic	Address of Physician/Clinic
_____ (MM/DD/YYYY)	_____	_____
_____ (MM/DD/YYYY)	_____	_____
_____ (MM/DD/YYYY)	_____	_____

If you are seeking benefits based on the results of this Echocardiogram(s), you must attach a copy of each Echocardiogram report and include the videotape or disk of the Echocardiogram as part of your Claim submission.

² An Echocardiogram is a test in which sound waves are passed through the chest to result in a video image of the heart and its valves. It should not be confused with an "electrocardiogram" in which sensors are placed at various locations on the body and a paper readout is generated.



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[REDACTED]

12. If you answered "Yes" to Question #11, answer the following to the best of your knowledge:

- a. Did any show mild or greater aortic regurgitation? ☐ Yes ☐ No
- b. Did any show moderate or greater mitral regurgitation? ☐ Yes ☐ No
- c. Did any show mild mitral regurgitation? ☐ Yes ☐ No
- d. Don't know ☐

If you answered "Yes" to Questions #12.a, #12.b, or if you checked the box for #12.d, you must submit a GRAY FORM or GREEN FORM to complete your Claim.

If you answered "Yes" to Question #12.c, you should file a GRAY FORM to preserve your future rights under the Settlement Agreement. (See page 8, Item 6 for a more detailed explanation of the GRAY FORM.)

13. If you would like to receive information about the Compassionate and Humanitarian program described in the Official Notice, call 1-800-386-2070.

14. If you would like to receive information concerning reimbursement benefits for all or part of the cost of certain privately-obtained Echocardiograms, call 1-800-386-2070.

15. State whether you elect to receive cash benefits or medical services³ if you qualify for this benefit. Such benefits or services will only become available to you if the AHP Settlement Trust determines that you are eligible. To seek this benefit, you must complete, sign and mail to the AHP Settlement Trust this BLUE FORM postmarked no later than May 3, 2003. You may select only one option.

☒ I elect to receive \$6,000 in cash if the AHP Settlement Trust determines that I took the diet drugs Pondimin[®] and/or Redux[™] 61 days or more, and I am diagnosed as "FDA Positive" on or before January 3, 2003, or \$3,000 in cash if the AHP Settlement Trust determines that I took the diet drugs Pondimin[®] and/or Redux[™] for 60 days or less, and I am diagnosed as "FDA Positive" on or before January 3, 2003.

OR

☐ I elect to receive \$10,000 in heart valve-related medical services if the AHP Settlement Trust determines that I took the diet drugs Pondimin[®] and/or Redux[™] 61 days or more, and I am diagnosed as "FDA Positive" on or before January 3, 2003, or \$5,000 in heart valve related medical services if the AHP Settlement Trust determines that I took the diet drugs Pondimin[®] and/or Redux[™] for 60 days or less, and I am diagnosed as "FDA Positive" on or before January 3, 2003.

16. Do you believe that you have any medical condition which qualifies for payment on the Compensation Matrices described in the *Official Notice of Final Judicial Approval*?

☐ Yes ☐ No

Note: If you answered "Yes" to the previous question, you and a Board-Certified Cardiologist and/or Board-Certified Cardiothoracic Surgeon (and in some instances, a Board-Certified Pathologist, Board-Certified Neurologist or Board-Certified Neurosurgeon) also must complete the separate Matrix Benefits Compensation Claim Form—the GREEN FORM—to obtain the benefit.

³ The medical services shall be limited to the care of Valvular Heart Disease. The Trustees may include the following services, when performed, supervised, or prescribed by a physician specializing in internal medicine, cardiology or cardiothoracic surgery: comprehensive physical examinations, chest x-rays, electrocardiograms, standard laboratory testing, medically-appropriate Echocardiograms, and/or medically-supervised nutritional counseling and/or any accepted technology or techniques for the management of valvular heart disease.



17. **Confidentiality.** By signing below, I authorize disclosure of the information contained in this form and any other documents supplied in connection with my claim to such persons as may be reasonably necessary for purposes of processing any claim and providing any benefits under the Settlement Agreement.

18. **CONDITIONAL RELEASE OF SETTLED CLAIMS AND COVENANT NOT TO SUE.** In consideration of the obligations of American Home Products Corporation ("AHP") under the Nationwide Class Action Settlement Agreement with American Home Products Corporation ("Settlement Agreement") approved by the United States District Court for the Eastern District of Pennsylvania, I, the undersigned claimant, individually and for my heirs, beneficiaries, agents, estate, executors, administrators, personal representatives, successors and assignees, and/or, if the undersigned claims as a representative of the person who used Pondimin® and/or Redux®, whether as heir, beneficiary, agent, estate, executor, administrator, personal representative, successor, assignee, guardian, or otherwise, and in that capacity, or, if applicable, the undersigned as a person who has a Derivative Claim under the Settlement Agreement, and in that capacity, hereby expressly **release and forever discharge, and agree not to sue**, AHP and all other Released Parties (as defined in the Settlement Agreement) as to all Settled Claims (as defined in the Settlement Agreement), asserted against AHP or any Released Party. The Settlement Agreement, including, without limitation its benefit and its release provisions, and the definitions of the terms "Settled Claims" and "Released Parties," is incorporated by reference as if fully set out at length. I further agree to the provisions of the Settlement Agreement concerning "Judgment Reduction for Claims by Third Parties" which are summarized in the Notice of Settlement. For purposes of this Conditional Release of Settled Claims and Covenant not to Sue, the terms "Settled Claims" and "Released Parties" are defined as set forth in the Settlement Agreement and in the Notice of Settlement. I understand that certain principles of law, such as those reflected in statutes like Sect on 1542 of the California Civil Code and in the common law of many states, provide that a release may not extend to claims which the undersigned does not know or suspect to exist. I am aware that I may discover claims presently unknown or unsuspected, or facts in addition to or different from those which I now believe to be true with respect to the matters released herein which may be applicable to this settlement. **Nevertheless, I hereby knowingly and voluntarily relinquish the protections of Section 1542 and all similar federal or state laws, rights, rules or legal principles that may be applicable.** In the event that the undersigned properly exercises any Intermediate or Back-End Opt-Out rights under the Settlement Agreement, then this conditional release shall be null and void and of no further force and effect except to the extent provided in Section IV.D of the Settlement Agreement. **I, THE UNDERSIGNED, HAVE CAREFULLY READ (OR HAVE HAD READ TO ME) THIS CONDITIONAL RELEASE OF SETTLED CLAIMS AND COVENANT NOT TO SUE. I, THE UNDERSIGNED, UNDERSTAND THE TERMS OF IT, AND AGREE TO BE BOUND BY IT.**

19. **Declaration under Penalty of Perjury.** Each person signing below acknowledges and understands that this form is an official Court document sanctioned by the Court that presides over the Diet Drug Settlement, and submitting it to the AHP Settlement Trust is equivalent to filing it with a Court. Each agrees to cooperate with the AHP Settlement Trust and to provide any necessary medical record authorization and releases for the AHP Settlement Trust to gather information needed to substantiate or audit the Claim. Each declares under penalty of perjury that the information provided in this form is true and correct to the best of his/her knowledge, information and belief.

Lynette Patterson
(Signature of Diet Drug Recipient, if living)

Date: 04/31/2004
(MM/DD/YYYY)

(Signature(s) of Legal Representative(s) of Diet Drug Recipient, if any)

Date: ____/____/____
(MM/DD/YYYY)

(Signature(s) of Claiming Spouse, Parent, Child, Dependent, Other Relative, or "Significant Other," if any)

Date: ____/____/____
(MM/DD/YYYY)

(NOTE—Copy this page if you need room for additional signatures, and include copied and signed pages with this form.)

BLUE FORM - 7



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REMEMBER: *To complete your Claim, you must supply the following to the AHP Settlement Trust:*

1. Written proof of the amount of Pondimin® and/or Redux™ which was dispensed for your use by your drugstore(s), pharmacy(ies), doctor(s), clinic(s) or health care facility(ies).
2. If you are submitting this form as a Representative Claimant, a copy of the order or other document appointing you as the Diet Drug Recipient's legal representative.
3. If you are representing a deceased's estate, a copy of the death certificate, along with a copy of any letters of administration or probate or surrogate certificate.
4. A signed Authorization for the Release of Medical Records included in this form.
5. If you are seeking benefits based on the results of an Echocardiogram(s) that you identified in Question #11, you must supply a copy of each Echocardiogram report and the videotape or disk of each.
6. A GRAY FORM if you are claiming Benefits based upon an Echocardiogram performed after September 30, 1999.
The GRAY FORM must be accompanied by the report of the results of the Echocardiogram and a copy of the Echocardiogram tape or disk.
7. If you claim Matrix Compensation Benefits, you and your doctor must complete the Matrix Compensation Benefits Claim Form—the GREEN FORM—and mail it to:

**AHP Settlement Trust
P.O. Box 7939
Philadelphia, PA 19101**

If you change your address, you must promptly notify the AHP Settlement Trust in writing of your new address.

For assistance call 1-800-386-2070, or access the AHP Settlement Trust's website at <http://www.settlementdietdrugs.com>.

BLUE FORM - 8



**AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS
AND OTHER HEALTH INFORMATION**

I hereby authorize the use or disclosure of my individually identifiable health information and medical records as described below. I understand that this authorization is voluntary. I understand that because the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations, but it will be subject to the confidentiality provisions of the Nationwide Class Action Settlement Agreement with American Home Products Corporation.

Information Authorized for Release: All prescribing or dispensing physician medical records (including information identifying the undersigned Diet Drug Recipient or patient, the diet drug name, the date(s) prescribed, the dosage and duration the drug was dispensed), echocardiograph recordings and reports (including written reports and echocardiograph videotapes and disks), prescription dispensing records from a pharmacy or other entity (including the drug name, quantity, frequency, dosage, and number of refills, prescribing physician's name, original fill date and each subsequent refill date), and billing records and/or payment records that relate to the Echocardiogram(s) and/or the dispensation of the diet drugs.

I authorize the release of the above records/recordings to the AHP Settlement Trust. The AHP Settlement Trust will pay reasonable charges made by you in accordance with limitations imposed on the Trust by Pretrial Order 1665 - Establishing a Limit on Fees for Retrieval and Copying of Medical Records, to supply copies of such furnished records/or disks.

Patient/Diet Drug Recipient:

Courtney Patricia
(First Name) (Middle Initial) (Last Name)

Date of birth and Social Security Number of Patient/Diet Drug Recipient:

03/10/1950 557-68-7453
(Birth Date MM/DD/YYYY) (Social Security Number)

Persons/Organizations Providing the Information: Any organization maintaining records described above that are necessary to adjudicate the relevant Claim filed under the Nationwide Class Action Settlement Agreement with American Home Products Corporation.

Mail the above records to:

AHP Settlement Trust
P.O. Box 7939
Philadelphia, PA 19101

I understand that this authorization will expire three (3) years from the date I sign this document as indicated below. In addition, I understand that I may revoke this authorization at any time by notifying the AHP Settlement Trust and the providing organization in writing, but if I do revoke this authorization it will not have any effect on any actions any providing organization took before it received the revocation. Copies of this authorization shall be honored as originals. Also, this authorization does not authorize the disclosure of any information other than the items referenced above.

Patricia 03/10/1950
Signature of Patient/Diet Drug Recipient or Authorized Representative (Date MM/DD/YYYY)

(If applicable) Printed Name of Authorized Representative: _____

(If applicable) Relationship of Representative to Patient/Diet Drug Recipient: _____

BLUE FORM - 9



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Diet Drug Settlement With American Home Products Corporation

Declaration of Prescribing Physician or Dispensing Pharmacy

Use this form **ONLY IF** your pharmacy/prescription record(s) are unobtainable as described in Question #10 on pages 4 and 5 of this form. This form is to be completed, if necessary, by the doctor who prescribed Pondimin® and/or Redux™, or the pharmacy that dispensed Pondimin® and/or Redux™. Make copies of this form as needed.

I prescribed/dispensed Pondimin® and/or Redux™ for the following patient:

(First Name) _____
(Middle Initial) _____
(Last Name)

(Birth Date—If known) _____
(Social Security Number—If known)

I am:

- ☐ The physician who prescribed Pondimin® and/or Redux™ to the patient identified above.
☐ The pharmacist who dispensed Pondimin® and/or Redux™ to the patient identified above.

I prescribed or dispensed Pondimin® and/or Redux™ to the patient identified above as set forth in the following chart:

Drug Name	Dosage	Approximate Start Date			Approximate End Date			Number of Pills Per Day
		Month	Day	Year	Month	Day	Year	

This Declaration is an official document sanctioned by the Court and submitting it to the AHP Settlement Trust is equivalent to filing it with a court. I declare under penalty of perjury that all of the information provided in this Declaration is true and correct to the best of my knowledge, information and belief.

(Signature)

(Date MM/DD/YYYY)

(Printed Name)

BLUE FORM - 11



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SUMMARY OF DEADLINES FOR MAILING THE BLUE FORM			
WHAT YOU WANT TO DO		OTHER FORMS YOU MUST MAIL WITH THE BLUE FORM FOR THIS CHOICE	POSTMARK DEADLINE TO MAIL FORMS
SEEK FUND A MEDICAL MONITORING BENEFITS	Free Echocardiogram in the AHP Settlement Trust's Screening Program	None	August 1, 2002
	Free Echocardiogram in the Compassionate and Humanitarian Program	BROWN FORM	August 1, 2002
	Reimbursement for Echocardiogram received outside the AHP Settlement Trust's Screening Program (for those benefits not dependent on whether the Trust has sufficient funds)	WHITE FORM and GRAY FORM	Mail BLUE and WHITE FORMs by May 3, 2003. Mail GRAY FORM as soon as possible after Echo.
	Reimbursement for Echocardiogram received outside the AHP Settlement Trust's Screening Program (if the Trust has sufficient funds)	WHITE FORM	August 1, 2002
	Cash or Additional Medical Services	GRAY FORM (if Echo after 9/30/99)	Mail BLUE FORM by May 3, 2003
	Refund of Prescription Costs	None	August 1, 2002
SEEK FUND B MATRIX BENEFITS	Compensation for Matrix-Level Conditions You Have Now	GREEN FORM	Mail BLUE FORM by May 3, 2003. Mail GREEN FORM by December 31, 2015.
	Preserve the Right to Seek Matrix-Level Benefits in the Future	GRAY FORM and GREEN FORM	Mail BLUE FORM by May 3, 2003. Mail GRAY FORM as soon as possible after Echo. Mail GREEN FORM by December 31, 2015.
SEEK TO OPT OUT OF SETTLEMENT	Back-End Opt-Out (Must be diagnosed as FDA Positive or having mild mitral regurgitation by January 3, 2003, must reach a Matrix-Level condition for the first time after September 30, 1999, and must meet other requirements)	ORANGE FORM #3	Mail BLUE Form by May 3, 2003. File ORANGE FORM #3 no later than May 3, 2003, or 120 days after the Diet Drug Recipient knew or should have known of the Matrix-Level condition.

BLUE FORM - 12

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EXHIBIT “5”

BLUE FORM

Diet Drug Settlement With American Home Products Corporation

RECEIVED

JUN 08 2003

By: _____

NOTICE: You do not need to complete this form if you have already submitted either a completed and signed PINK FORM under the Accelerated Implementation Option or a completed and signed BLUE FORM.

This BLUE FORM is to be used by any Class Member who wants to register for Settlement Benefits and must be mailed to the AHP Settlement Trust postmarked no later than August 1, 2002, for certain benefits and no later than May 3, 2003, for other benefits. To understand these deadlines fully, see the Chart on page 12 of this form, the *Official Notice of Final Judicial Approval*, or the Settlement Agreement.

Print or type all responses. By completing this BLUE FORM you are registering for benefits under the Settlement. If you have retained a lawyer regarding your use of diet drugs, you should consult him or her about your options under the Settlement.

Do not detach or separate bound Claim Forms.

1. Complete the following information for the Diet Drug Recipient (the person who used the diet drugs).

Cynthia (First Name) Pat (Middle Initial) Pattison (Last Name)
Cindy (List all other names that you use or have used during the last ten years)
705 Santa Cruz Ln (Street Address)
Foster City (City) Calif (State) 94404 (Zip Code)
4150333-4111 (Daytime Area Code & Phone Number) 41501575-19270 (Evening Area Code & Phone Number)
WBCAStreet.com (E-mail Address, if any)
03/30/1950 (Birth Date MM/DD/YYYY) 559-165-17453

U.S. Postal Service
CERTIFIED MAIL RECEIPT
 (Domestic Mail Only; No Insurance Coverage)

Postage	\$ 57
Certified Fee	2.10
Return Receipt Fee (if no return requested)	1.50
Registered Delivery Fee (if no return requested)	
Total Postage & Fees	\$ 4.17

Recipient's Name (Please Print Clearly) (To be completed by the
 AHP Settlement Trust
 Attn: AHP No. or PO Box No.
 P.O. Box 7939

SENDER:

- Complete items 1 and/or 2 for additional services.
- Complete items 3, 4a, and 4b.
- Print your name and address on the reverse of this form so that we can return the card to you.
- Attach this form to the front of the mailpiece, or on the back if space does not permit.
- Write "Return Receipt Requested" on the mailpiece below the article number.
- The Return Receipt will show to whom the article was delivered and the date delivered.

3. Article Addressed to:
 AHP Settlement Trust
 P.O. Box 7939
 Philadelphia, PA 19101

5. Received By: (Print Name)

6. Signature (Addressee or Agent)

I also wish to receive the following services (for an extra fee).

- ☐ Addressee's Address
 - ☐ Restricted Delivery
- Consult postmaster for fee.

4a. Article Number
 7000 0520 0022 4922 6607
 4b. Service Type
☐ Registered ☒ Certified
☐ Express Mail ☐ Insured
☐ Return Receipt (if no return requested) ☒ Signature Required
 7. Date of Delivery

8. Addressee's Address (Only if requested and fee is paid)

2. Are you completing this questionnaire as the "Representative Claimant" (i.e., estate, administrator, other legal representative, heir or beneficiary of a Diet Drug Recipient)?

☒ No (skip to Question #3) ☐ Yes (complete the following)

(First Name) (Middle Initial) (Last Name)

(Street Address)

(City) (State) (Zip Code)

(Daytime Area Code & Phone Number) (Evening Area Code & Phone Number)

(E-mail Address, if any)

(Your relationship to the Diet Drug Recipient)

If you are a Representative Claimant, attach a copy of the order or document appointing you the Diet Drug Recipient's legal representative.

If you are representing a deceased's estate, attach an official copy of the death certificate along with a copy of any letters of administration, probate or surrogate certificate. State the date of death:

Date of Death _____
(MM/DD/YYYY)

3. Are you completing this questionnaire as a "Derivative Claimant" (i.e., a spouse, child, dependent, parent, other relative or "significant other" of a Diet Drug Recipient)?

☒ No (go to Question #5) ☐ Yes (go to Question #4)

- 4.a. Provide the following information concerning each "Derivative Claimant." (If there is more than one, check here ☐ and either copy this section of the form or use another copy of this form to provide the information. Include that paper with this form.)

(First Name) (Middle Initial) (Last Name)

(Street Address)

(City) (State) (Zip Code)

(Daytime Area Code & Phone Number) (Evening Area Code & Phone Number)

(E-mail Address, if any)

(Birth Date MM/DD/YYYY) (Social Security Number)

BLUE FORM - 2



b. Specify the relationship of the Derivative Claimant to the Diet Drug Recipient.

- ☐ Spouse ☐ Dependent, specify _____
☐ Parent ☐ Other relative, specify _____
☐ Child ☐ Significant other, specify _____

c. If you selected "Spouse" above, what is the current status of the relationship of the Derivative Claimant to the Diet Drug Recipient?

- ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Date of the marriage: ____/____/____
(MM/DD/YYYY)

d. If you, the Derivative Claimant, are currently estranged from the Diet Drug Recipient, state the date of separation and/or divorce.

Date: ____/____/____
(MM/DD/YYYY)

(Provide evidence of the date of separation or divorce, i.e., separation agreement or divorce decree).

e. Identify the basis on which the Derivative Claimant is claiming "derivative" benefits.

- ☐ Loss of Consortium/Per Quod (e.g., loss of marital services and relationship)
☐ Loss of Support
☐ Loss of Service
☐ Other, explain: _____

NOTE: Each Claimant (including Representative and/or Derivative Claimants) must sign the Declaration under Penalty of Perjury on page 7 of this BLUE FORM (making copies if necessary) and submit it with this form.

5. Are you represented by any lawyer in connection with this Claim?

- ☒ Yes ☐ No

6. If you answered "Yes" to Question #5, provide the following information:

(Law Firm Name)

Lawrence
(Attorney's First Name)

W. Schaubert
(Middle Initial) (Last Name)

(Street Address)

86 Eucalyptus Road
(Street Address)

Berkeley
(City)

Ca
(State)

94705
(Zip Code)

(Daytime Area Code & Phone Number)

(Fax Area Code & Number)

(E-mail Address, if any)

BLUE FORM - 3



NOTE: If you are completing this questionnaire as a Representative or Derivative Claimant, the following questions using the term "You" refer to the "Diet Drug Recipient."

7. State whether you were prescribed and took the following Diet Drugs:
- Pondimin® (Fenfluramine) ☒ Yes ☐ No
- Redux® (Dexfenfluramine) ☒ Yes ☐ No
8. Indicate by checking the appropriate box below the total period of time that you took Pondimin® and/or Redux®:
- (If you took both drugs, add together the period of time you used each drug to determine the total period of use.)
- ☐ 60 days or less ☒ 61 days or more
9. State the total number of days that you used each of the following diet drugs:
- Pondimin® _____ days
- Redux® 448 days
- You bear the ultimate responsibility for providing records to substantiate the total number of days you used Pondimin® and/or Redux®.
10. You must provide the information requested below.
- a. If the diet drug (Pondimin® and/or Redux®) was dispensed by a pharmacy, identify the pharmacy name, address and telephone number.
- COSTCO PHARMACY #147
(Pharmacy Name)
- 1001 METRO CENTER BLVD
(Street Address)
- FOSTER CITY CA 94404
(City) (State) (Zip Code)
- 650.286.2759
(Area Code and Phone Number)

[If there was more than one pharmacy that dispensed the diet drugs Pondimin® and/or Redux®, make a copy or copies of this page and provide the information for each such pharmacy and include those additional sheets with this form.]

Provide a copy of the pharmacy prescription dispensing records (e.g., prescription printouts, pharmacy records, prescription forms) from each pharmacy, which should include the medication name, quantity, frequency, dosage and number of refills prescribed, prescribing physician's name, assigned prescription number, original fill date and each subsequent refill date.

OR

* The "Diet Drug Recipient" is the person who took Pondimin®, Redux®, and/or the drug combination commonly known as "Fen-Phen."

BLUE FORM - 4



- b. If the diet drug (Pondimin® and/or Redux®) was dispensed directly by a physician or weight loss clinic, or the pharmacy record(s) is unobtainable, state the name of each physician who prescribed the diet drug, and the address and telephone number of that physician:

 (First Name of Prescribing Physician) (Middle Initial) (Last Name)

 (Name of Weight Loss Clinic, if applicable)

 (Street Address)

 (City) (State) (Zip Code)

 (Area Code & Telephone Number)

[If there was more than one physician or weight loss clinic that prescribed and/or dispensed the diet drugs Pondimin® and/or Redux®, make a copy or copies of this page and provide the information for each such physician or weight loss clinic and include those additional sheets with this form.]

Provide a copy of the medical record(s) reflecting the prescription and/or dispensing of the diet drugs. This must include records that identify the Diet Drug Recipient, the diet drug name, the date(s) prescribed, the dosage and duration for which the drug was prescribed or dispensed.

If, and only if, the pharmacy record(s) or prescribing physician's medical record(s) are unobtainable, check here ☐ and have your prescribing physician or dispensing pharmacist complete the attached Declaration of Prescribing Physician or Dispensing Pharmacy.

11. Have you had an Echocardiogram¹ after you first started using diet drugs?

☐ Yes ☒ No

If yes, state the date(s) of each Echocardiogram(s) and the name and address of each physician who performed the Echocardiogram or reported the results to you

Date	Name of Physician/Clinic	Address of Physician/Clinic
_____ (MM/DD/YYYY)	_____	_____
_____ (MM/DD/YYYY)	_____	_____
_____ (MM/DD/YYYY)	_____	_____

If you are seeking benefits based on the results of this Echocardiogram(s), you must attach a copy of each Echocardiogram report and include the videotape or disk of the Echocardiogram as part of your Claim submission.

¹ An Echocardiogram is a test in which sound waves are passed through the chest to result in a video image of the heart and its valves. It should not be confused with an "electrocardiogram" in which sensors are placed at various locations on the body and a paper readout is generated.



12. If you answered "Yes" to Question #11, answer the following to the best of your knowledge:

- a. Did any show mild or greater aortic regurgitation? ☐ Yes ☐ No
 b. Did any show moderate or greater mitral regurgitation? ☐ Yes ☐ No
 c. Did any show mild mitral regurgitation? ☐ Yes ☐ No
 d. Don't know ☐

If you answered "Yes" to Questions #12 a, #12 b, or if you checked the box for #12 d, you must submit a GRAY FORM or GREEN FORM to complete your Claim.

If you answered "Yes" to Question #12 c, you should file a GRAY FORM to preserve your future rights under the Settlement Agreement. (See page 8, Item 6 for a more detailed explanation of the GRAY FORM.)

13. If you would like to receive information about the Compassionate and Humanitarian program described in the Official Notice, call 1-800-386-2070.

14. If you would like to receive information concerning reimbursement benefits for all or part of the cost of certain privately-obtained Echocardiograms, call 1-800-386-2070.

15. State whether you elect to receive cash benefits or medical services¹ if you qualify for this benefit. Such benefits or services will only become available to you if the AHP Settlement Trust determines that you are eligible. To seek this benefit, you must complete, sign and mail to the AHP Settlement Trust this BLUE FORM postmarked no later than May 3, 2003. You may select only one option.

- ☒ I elect to receive \$6,000 in cash if the AHP Settlement Trust determines that I took the diet drugs Pondimin® and/or Redux® 61 days or more, and I am diagnosed as "FDA Positive" on or before January 3, 2003, or \$3,000 in cash if the AHP Settlement Trust determines that I took the diet drugs Pondimin® and/or Redux® for 60 days or less, and I am diagnosed as "FDA Positive" on or before January 3, 2003.

OR

- ☐ I elect to receive \$10,000 in heart valve-related medical services if the AHP Settlement Trust determines that I took the diet drugs Pondimin® and/or Redux® 61 days or more, and I am diagnosed as "FDA Positive" on or before January 3, 2003, or \$5,000 in heart valve related medical services if the AHP Settlement Trust determines that I took the diet drugs Pondimin® and/or Redux® for 60 days or less, and I am diagnosed as "FDA Positive" on or before January 3, 2003.

16. Do you believe that you have any medical condition which qualifies for payment on the Compensation Matrices described in the Official Notice of Final Judicial Approval?

- ☐ Yes ☐ No

Note: If you answered "Yes" to the previous question, you and a Board-Certified Cardiologist and/or Board-Certified Cardiothoracic Surgeon (and in some instances, a Board-Certified Pathologist, Board-Certified Neurologist or Board-Certified Neurosurgeon) also must complete the separate Matrix Benefits Compensation Claim Form—the GREEN FORM—to obtain the benefit.

¹The medical services shall be limited to the care of Valvular Heart Disease. The Trustees may include the following services, when performed, supervised or prescribed by a physician specializing in internal medicine, cardiology or cardiothoracic surgery: comprehensive physical examinations, chest X-rays, electrocardiograms, standard laboratory testing, medically appropriate Echocardiograms, and/or medically supervised nutritional counseling and/or any accepted technology or techniques for the management of valvular heart disease.



17. Confidentiality. By signing below, I authorize disclosure of the information contained in this form and any other documents supplied in connection with my claim to such persons as may be reasonably necessary for purposes of processing any claim and providing any benefits under the Settlement Agreement.

18. **CONDITIONAL RELEASE OF SETTLED CLAIMS AND COVENANT NOT TO SUE.** In consideration of the obligations of American Home Products Corporation ("AHP") under the Nationwide Class Action Settlement Agreement with American Home Products Corporation ("Settlement Agreement") approved by the United States District Court for the Eastern District of Pennsylvania, I, the undersigned claimant, individually and for my heirs, beneficiaries, agents, estate, executors, administrators, personal representatives, successors and assignees, and/or, if the undersigned claims as a representative of the person who used Pondimin[®] and/or Redux[™], whether as heir, beneficiary, agent, estate, executor, administrator, personal representative, successor, assignee, guardian, or otherwise, and in that capacity, or, if applicable, the undersigned as a person who has a Derivative Claim under the Settlement Agreement, and in that capacity, hereby expressly release and forever discharge, and agree not to sue, AHP and all other Released Parties (as defined in the Settlement Agreement) as to all Settled Claims (as defined in the Settlement Agreement), asserted against AHP or any Released Party. The Settlement Agreement, including, without limitation its benefit and its release provisions, and the definitions of the terms "Settled Claims" and "Released Parties," is incorporated by reference as if fully set out at length. I further agree to the provisions of the Settlement Agreement concerning "Judgment Reduction for Claims by Third Parties" which are summarized in the Notice of Settlement. For purposes of this Conditional Release of Settled Claims and Covenant not to Sue, the terms "Settled Claims" and "Released Parties" are defined as set forth in the Settlement Agreement and in the Notice of Settlement. I understand that certain principles of law, such as those reflected in statutes like Section 1542 of the California Civil Code and in the common law of many states, provide that a release may not extend to claims which the undersigned does not know or suspect to exist. I am aware that I may discover claims presently unknown or unsuspected, or facts in addition to or different from those which I now believe to be true with respect to the matters released herein which may be applicable to this settlement. Nevertheless, I hereby knowingly and voluntarily relinquish the protections of Section 1542 and all similar federal or state laws, rights, rules or legal principles that may be applicable. In the event that the undersigned properly exercises any Intermediate or Back-End Opt-Out rights under the Settlement Agreement, then this conditional release shall be null and void and of no further force and effect except to the extent provided in Section IV D of the Settlement Agreement. I, THE UNDERSIGNED, HAVE CAREFULLY READ (OR HAVE HAD READ TO ME) THIS CONDITIONAL RELEASE OF SETTLED CLAIMS AND COVENANT NOT TO SUE. I, THE UNDERSIGNED, UNDERSTAND THE TERMS OF IT, AND AGREE TO BE BOUND BY IT.

19. **Declaration under Penalty of Perjury.** Each person signing below acknowledges and understands that this form is an official Court document sanctioned by the Court that presides over the Diet Drug Settlement, and submitting it to the AHP Settlement Trust is equivalent to filing it with a Court. Each agrees to cooperate with the AHP Settlement Trust and to provide any necessary medical record authorization and releases for the AHP Settlement Trust to gather information needed to substantiate or audit the Claim. Each declares under penalty of perjury that the information provided in this form is true and correct to the best of his/her knowledge, information and belief.

Cynthia Patterson

(Signature of Diet Drug Recipient, if any)

Date: 03/25/2002
(MM/DD/YYYY)

(Signature(s) of Legal Representative(s) of Diet Drug Recipient, if any)

Date: 1/1/00
(MM/DD/YYYY)

(Signature(s) of Claiming Spouse, Parent, Child, Dependent, Other Relative, or "Significant Other," if any)

Date: 1/1/00
(MM/DD/YYYY)

(NOTE:—Copy this page if you need room for additional signatures, and include copied and signed pages with this form.)

BLUE FORM - 7



REMEMBER: To complete your Claim, you must supply the following to the AHP Settlement Trust:

1. Written proof of the amount of Pondimin® and/or Redux® which was dispensed for your use by your drugstore(s), pharmacy(ies), doctor(s), clinic(s) or health care facility(ies).
2. If you are submitting this form as a Representative Claimant, a copy of the order or other document appointing you as the Diet Drug Recipient's legal representative.
3. If you are representing a deceased's estate, a copy of the death certificate, along with a copy of any letters of administration or probate or surrogate certificate.
4. A signed Authorization for the Release of Medical Records included in this form.
5. If you are seeking benefits based on the results of an Echocardiogram(s) that you identified in Question #11, you must supply a copy of each Echocardiogram report and the videotape or disk of each.
6. A GRAY FORM if you are claiming Benefits based upon an Echocardiogram performed after September 30, 1999.
The GRAY FORM must be accompanied by the report of the results of the Echocardiogram and a copy of the Echocardiogram tape or disk.
7. If you claim Matrix Compensation Benefits, you and your doctor must complete the Matrix Compensation Benefits Claim Form—the GREEN FORM—and mail it to:

AHP Settlement Trust
P.O. Box 7939
Philadelphia, PA 19101

If you change your address, you must promptly notify the AHP Settlement Trust in writing of your new address.

For assistance call 1-800-386-2070, or access the AHP Settlement Trust's website at <http://www.settlementdietdrug.com>

BLUE FORM - 8



**AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS
AND OTHER HEALTH INFORMATION**

I hereby authorize the use or disclosure of my individually identifiable health information and medical records as described below. I understand that this authorization is voluntary. I understand that because the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations, but it will be subject to the confidentiality provisions of the Nationwide Class Action Settlement Agreement with American Home Products Corporation.

Information Authorized for Release: All prescribing or dispensing physician medical records (including information identifying the undersigned Diet Drug Recipient or patient, the diet drug name, the date(s) prescribed, the dosage and duration the drug was dispensed), echocardiograph recordings and reports (including written reports and echocardiograph videotapes and disks), prescription dispensing records from a pharmacy or other entity (including the drug name, quantity, frequency, dosage, and number of refills, prescribing physician's name, original fill date and each subsequent refill date), and billing records and/or payment records that relate to the Echocardiogram(s) and/or the dispensation of the diet drugs.

I authorize the release of the above records/recordings to the AHP Settlement Trust. The AHP Settlement Trust will pay reasonable charges made by you in accordance with limitations imposed on the Trust by Pretrial Order 1665 - Establishing a Limit on Fees for Retrieval and Copying of Medical Records, to supply copies of such furnished records/or disks.

Patient/Diet Drug Recipient:

Cynthia Pat Pattison
(First Name) (Middle Initial) (Last Name)

Date of birth and Social Security Number of Patient/Diet Drug Recipient:

03/30/1950 559-168-7453
(Birth Date MM/DD/YYYY) (Social Security Number)

Persons/Organizations Providing the Information: Any organization maintaining records described above that are necessary to adjudicate the relevant Claim filed under the Nationwide Class Action Settlement Agreement with American Home Products Corporation.

Mail the above records to:

AHP Settlement Trust
P.O. Box 7939
Philadelphia, PA 19101

I understand that this authorization will expire three (3) years from the date I sign this document as indicated below. In addition, I understand that I may revoke this authorization at any time by notifying the AHP Settlement Trust and the providing organization in writing, but if I do revoke this authorization it will not have any effect on any actions any providing organization took before it received the revocation. Copies of this authorization shall be honored as originals. Also, this authorization does not authorize the disclosure of any information other than the items referenced above.

Cynthia Pattison 03/25/1950
Signature of Patient/Diet Drug Recipient or Authorized Representative (Date MM/DD/YYYY)

(If applicable) Printed Name of Authorized Representative: _____

(If applicable) Relationship of Representative to Patient/Diet Drug Recipient: _____

BLUE FORM - 9



Diet Drug Settlement With American Home Products Corporation

Declaration of Prescribing Physician or Dispensing Pharmacy

Use this form **ONLY IF** your pharmacy/prescription record(s) are unobtainable as described in Question #10 on pages 4 and 5 of this form. This form is to be completed, if necessary, by the doctor who prescribed Pondimin® and/or Redux™, or the pharmacy that dispensed Pondimin® and/or Redux™. Make copies of this form as needed.

I prescribed/dispensed Pondimin® and/or Redux™ for the following patient:

(First Name) (Middle Initial) (Last Name)

(Birth Date—If known) (Social Security Number—If known)

I am:

- ☐ The physician who prescribed Pondimin® and/or Redux™ to the patient identified above.
☐ The pharmacist who dispensed Pondimin® and/or Redux™ to the patient identified above.

I prescribed or dispensed Pondimin® and/or Redux™ to the patient identified above as set forth in the following chart.

Drug Name	Dosage	Approximate Start Date			Approximate End Date			Number of Pills Per Day
		Month	Day	Year	Month	Day	Year	

This Declaration is an official document sanctioned by the Court and submitting it to the AHP Settlement Trust is equivalent to filing it with a court. I declare under penalty of perjury that all of the information provided in this Declaration is true and correct to the best of my knowledge, information and belief.

(Signature)

(Date MM/DD/YYYY)

(Printed Name)

BLUE FORM - 11



SUMMARY OF DEADLINES FOR MAILING THE BLUE FORM			
WHAT YOU WANT TO DO		OTHER FORMS YOU MUST MAIL WITH THE BLUE FORM FOR THIS CHOICE	POSTMARK DEADLINE TO MAIL FORMS
SEEK FUND A MEDICAL MONITORING BENEFITS	Free Echocardiogram in the AHP Settlement Trust's Screening Program	None	August 1, 2002
	Free Echocardiogram in the Compassionate and Humanitarian Program	BROWN FORM	August 1, 2002
	Reimbursement for Echocardiogram received outside the AHP Settlement Trust's Screening Program (for those benefits not dependent on whether the Trust has sufficient funds)	WHITE FORM and GRAY FORM	Mail BLUE and WHITE FORMs by May 3, 2003. Mail GRAY FORM as soon as possible after Echo.
	Reimbursement for Echocardiogram received outside the AHP Settlement Trust's Screening Program (if the Trust has sufficient funds)	WHITE FORM	August 1, 2002
	Cash or Additional Medical Services	GRAY FORM (if Echo after 9/30/99)	Mail BLUE FORM by May 3, 2003
	Refund of Prescription Costs	None	August 1, 2002
SEEK FUND B MATRIX BENEFITS	Compensation for Matrix-Level Conditions You Have Now	GREEN FORM	Mail BLUE FORM by May 3, 2003 Mail GREEN FORM by December 31, 2015
	Preserve the Right to Seek Matrix-Level Benefits in the Future	GRAY FORM and GREEN FORM	Mail BLUE FORM by May 3, 2003. Mail GRAY FORM as soon as possible after Echo. Mail GREEN FORM by December 31, 2015.
SEEK TO OPT OUT OF SETTLEMENT	Back-End Opt-Out (Must be diagnosed as FDA Positive or having mild mitral regurgitation by January 3, 2003; must reach a Matrix-Level condition for the first time after September 30, 1999, and must meet other requirements)	ORANGE FORM #3	Mail BLUE Form by May 3, 2003. File ORANGE FORM #3 no later than May 3, 2003, or 120 days after the Diet Drug Recipient knew or should have known of the Matrix-Level condition.

BLUE FORM - 12



EXHIBIT “6”

Claim Inquiry: DUFFY, ANGELA S - DDR # 2753499

DDR #	DDR Name	PIN	SSN	DoB	Admin Hold																		
2753499	DUFFY, ANGELA S 1002 LYLE LANE LAGRANGE, KY 40031	56254		7/7/1973																			
Attorney Information: <table border="1"> <thead> <tr> <th>Type</th> <th>Attorney</th> <th>Firm</th> <th>City</th> <th>State</th> </tr> </thead> <tbody> <tr> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>						Type	Attorney	Firm	City	State													
Type	Attorney	Firm	City	State																			
Claim Payments <table border="1"> <thead> <tr> <th>Type</th> <th>Check #</th> <th>Date</th> <th>Amount</th> <th>Status</th> <th>Clear Date</th> </tr> </thead> <tbody> <tr> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>						Type	Check #	Date	Amount	Status	Clear Date												
Type	Check #	Date	Amount	Status	Clear Date																		
General Deficiencies: <table border="1"> <thead> <tr> <th>Code</th> <th>Deficiency</th> <th>Def Date</th> <th>Cancel Date</th> <th>Notice Date</th> <th>Strikes</th> </tr> </thead> <tbody> <tr> <td>055</td> <td>FORM - NO PINK/BLUE/ORANGE1</td> <td>2/12/2003</td> <td></td> <td></td> <td></td> </tr> </tbody> </table>						Code	Deficiency	Def Date	Cancel Date	Notice Date	Strikes	055	FORM - NO PINK/BLUE/ORANGE1	2/12/2003									
Code	Deficiency	Def Date	Cancel Date	Notice Date	Strikes																		
055	FORM - NO PINK/BLUE/ORANGE1	2/12/2003																					
Green Deficiencies: <table border="1"> <thead> <tr> <th>Def Date</th> <th>Cancel Date</th> <th>Notice Date</th> <th>Strikes</th> </tr> </thead> <tbody> <tr> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>						Def Date	Cancel Date	Notice Date	Strikes														
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Green Form Data <table border="1"> <thead> <tr> <th>Physician</th> <th>Phys City</th> <th>State</th> <th>GF Mx</th> <th>GFA Mx</th> <th>Audit Mx</th> <th>Res</th> </tr> </thead> <tbody> <tr> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>						Physician	Phys City	State	GF Mx	GFA Mx	Audit Mx	Res											
Physician	Phys City	State	GF Mx	GFA Mx	Audit Mx	Res																	
Gray Data <table border="1"> <thead> <tr> <th>Status</th> <th>Physician</th> <th>Echo Date</th> <th>MR</th> <th>AR</th> </tr> </thead> <tbody> <tr> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>						Status	Physician	Echo Date	MR	AR													
Status	Physician	Echo Date	MR	AR																			
Document History <table border="1"> <thead> <tr> <th>Doc Code</th> <th>Document Type</th> <th>Rec Date</th> <th>Post Mark</th> <th>Box #</th> <th>DCN</th> </tr> </thead> <tbody> <tr> <td>10</td> <td>MISC.</td> <td>5/2/2000</td> <td></td> <td></td> <td>00123100001016</td> </tr> <tr> <td>10</td> <td>MISC.</td> <td>4/18/2000</td> <td></td> <td></td> <td>00109100001014</td> </tr> </tbody> </table>						Doc Code	Document Type	Rec Date	Post Mark	Box #	DCN	10	MISC.	5/2/2000			00123100001016	10	MISC.	4/18/2000			00109100001014
Doc Code	Document Type	Rec Date	Post Mark	Box #	DCN																		
10	MISC.	5/2/2000			00123100001016																		
10	MISC.	4/18/2000			00109100001014																		
Claim Activities: <table border="1"> <thead> <tr> <th>Activity</th> <th>Date</th> <th>Cancel Date</th> </tr> </thead> <tbody> <tr> <td></td> <td></td> <td></td> </tr> </tbody> </table>						Activity	Date	Cancel Date															
Activity	Date	Cancel Date																					

Friday, December 03, 2004

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EXHIBIT “7”

Claim Inquiry: DUFFY, ANGELA S - DDR # 8140581

DDR #	DDR Name	PIN	SSN	DoB	Admin Hold
8140581	DUFFY, ANGELA S 1002 LYLE LANE LAGRANGE, KY 400310000		349-78-4810	7/7/1973	
		Day Phone:	(502) 727-0486		
		NightPhone:	(502) 222-3589		

Attorney Information:

Type	Attorney	Firm	City	State
Primary	EDWARD W COCHRAN	EDWARD W COCHRAN	SHAKER HEIGHTS	OH
Co-Counsel	ROBERT W. BISHOP	BISHOP & ASSOCIATES	LOUISVILLE	KY

Claim Payments

Type	Check #	Date	Amount	Status	Clear Date
DRUG	2349168	7/22/2003	\$74.00		8/18/2003

General Deficiencies:

Code	Deficiency	Def Date	Cancel Date	Notice Date	Strikes
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Green Deficiencies:

Def Date	Cancel Date	Notice Date	Strikes
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Green Form Data

Physician	Phys City	State	GF Mx	GFA Mx	Audit Mx	Res
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Gray Data

Status	Physician	Echo Date	MR	AR
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Document History

Doc Code	Document Type	Rec Date	Post Mark	Box #	DCN
36	MEDICAL RECORDS	8/5/2002	7/31/2002		13133618140581
38	MEDICAL RECORDS AUTHORIZATION	8/5/2002	7/31/2002		13133818140581
42	NEW BLUE	8/5/2002	7/31/2002		13134218140581

Claim Activities:

Activity		Date	Cancel Date
PY_DRUG	BENEFIT PAID -- DRUG	7/22/2003	
SB_DRUG	SCHEDULED FOR BENEFIT -- DRUG	6/27/2003	7/22/2003
WY_DRUG	CLAIM AT WYETH ACCESS -- DRUG	6/20/2003	6/27/2003
WR_DRUG	READY FOR WYETH ACCESS -- DRUG	6/19/2003	6/20/2003
QA_DRUG	SCHEDULED FOR DRUG QA REVIEW	6/14/2003	6/19/2003
RV_ECHO	SCHEDULED FOR ECHO REVIEW	6/14/2003	
QA_ECHO	SCHEDULED FOR ECHO QA REVIEW	6/14/2003	
RV_CMS	SCHEDULED FOR CMS REVIEW	6/14/2003	
QA_CMS	SCHEDULED FOR CMS QA REVIEW	6/14/2003	
RV_DRUG	SCHEDULED FOR DRUG REVIEW	6/11/2003	6/19/2003
RV_DRUGD	REMOVED DRUG Q AS PER DENISE K.	5/14/2003	5/14/2003
FEFCLMLD	Final Echo follow up mailed - claimant copy	3/20/2003	
FEFATMLD	Final Echo follow up mailed - attorney copy	3/20/2003	
CCN_LTR	CCN Matching letter sent	2/18/2003	
PY_ESCR	SENT TO CRAWFORD FOR ECHO	1/22/2003	
LEE	Sent Echo Eligible letter	1/22/2003	
WR_ESCR	READY FOR WYETH ACCESS -- ESCR	1/22/2003	1/17/2003
WY_ESCR	CLAIM AT WYETH ACCESS -- ECHO	1/22/2003	1/17/2003
SB_ESCR	SCHEDULED FOR BENEFIT -- ECHO	1/22/2003	1/17/2003
ACKCLMLD	Acknowledgment Letter Mailed	10/29/2002	
BL1_REC	INITIAL BLUE INFORMATION IMPORTED FROM INDIA	10/8/2002	
CHK_ATT	ATTORNEY INFORMATION NEEDS REVIEW	10/8/2002	4/2/2003

Friday, December 03, 2004

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EXHIBIT “8”

BLUE FORM

Diet Drug Settlement With American Home Products Corporation

NOTICE: You do not need to complete this form if you have already submitted either a completed and signed PINK FORM under the Accelerated Implementation Option or a completed and signed BLUE FORM.

This BLUE FORM is to be used by any Class Member who wants to register for Settlement Benefits and must be mailed to the AHP Settlement Trust postmarked no later than August 1, 2002, for certain benefits and no later than May 3, 2003, for other benefits. To understand these deadlines fully, see the Chart on page 12 of this form, the *Official Notice of Final Judicial Approval*, or the Settlement Agreement.

Print or type all responses. By completing this BLUE FORM you are registering for benefits under the Settlement. If you have retained a lawyer regarding your use of diet drugs, you should consult him or her about your options under the Settlement.

Do not detach or separate bound Claim Forms.

1. Complete the following information for the Diet Drug Recipient (the person who used the diet drugs).

Angela Angie S. Duffy
(First Name) (Middle Initial) (Last Name)
Angela S. Milby
(List all other names that you use or have used during the last ten years)
1002 Lyle Lane
(Street Address)
La Grange KY 40031
(City) (State) (Zip Code)
502.727-0486 802.222-3589
(Daytime Area Code & Phone Number) (Evening Area Code & Phone Number)
asduffy46@hotmail.com
(E-mail Address, if any)
07071973 349-78-4816
(Birth Date MM/DD/YYYY) (Social Security Number)
 Gender: ☒ Female ☐ Male

Remove the BLUE FORM label from the Notice Package, affix here and fill out all information above.

Mail this form to:
 AHP Settlement Trust
 P.O. Box 7939
 Philadelphia, PA 19101

For assistance, call 1-800-386-2070
 Or access <http://www.settlementdietdrugs.com>

BLUE FORM - 1

AUG 28 2002



2. Are you completing this questionnaire as the "Representative Claimant" (i.e., estate, administrator, other legal representative, heir or beneficiary of a Diet Drug Recipient)?

☒ No (skip to Question #3) ☐ Yes (complete the following)

(First Name) (Middle Initial) (Last Name)

(Street Address)

(City) _____ (State) _____ (Zip Code) _____

()
(Daytime Area Code & Phone Number)

()
(Evening Area Code & Phone Number)

(E-mail Address, if any)

(Your relationship to the Diet Drug Recipient)

If you are a Representative Claimant, attach a copy of the order or document appointing you the Diet Drug Recipient's legal representative.

If you are representing a deceased's estate, attach an official copy of the death certificate along with a copy of any letters of administration, probate or surrogate certificate. State the date of death:

Date of Death:
(MM/DD/YYYY)

3. Are you completing this questionnaire as a "Derivative Claimant" (i.e., a spouse, child, dependent, parent, other relative or "significant other" of a Diet Drug Recipient)?

☒ No (go to Question #5) ☐ Yes (go to Question #4)

4.a. Provide the following information concerning each "Derivative Claimant." (If there is more than one, check here ☐ and either copy this section of the form or use another copy of this form to provide the information. Include that paper with this form.)

(First Name) _____ (Middle Initial) _____ (Last Name) _____

(Street Address)

(City) _____ (State) _____ (Zip Code) _____

()
(Daytime Area Code & Phone Number)

()
(Evening Area Code & Phone Number)

(E-mail Address, if any)

(Birth Date MM/DD/YYYY) _____ (Social Security Number) _____

BLUE FORM - 2



[REDACTED]

b. Specify the relationship of the Derivative Claimant to the Diet Drug Recipient.

- ☐ Spouse ☐ Dependent, specify _____
- ☐ Parent ☐ Other relative, specify _____
- ☐ Child ☐ Significant other, specify _____

c. If you selected "Spouse" above, what is the current status of the relationship of the Derivative Claimant to the Diet Drug Recipient?

- ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Date of the marriage: ____/____/____
(MM/DD/YYYY)

d. If you, the Derivative Claimant, are currently estranged from the Diet Drug Recipient, state the date of separation and/or divorce.

Date: ____/____/____
(MM/DD/YYYY)

(Provide evidence of the date of separation or divorce, i.e., separation agreement or divorce decree).

e. Identify the basis on which the Derivative Claimant is claiming "derivative" benefits.

- ☐ Loss of Consortium/Per Quod (e.g., loss of marital services and relationship)
- ☐ Loss of Support
- ☐ Loss of Service
- ☐ Other, explain: _____

NOTE: Each Claimant (including Representative and/or Derivative Claimants) must sign the Declaration under Penalty of Perjury on page 7 of this BLUE FORM (making copies if necessary) and submit it with this form.

5. Are you represented by any lawyer in connection with this Claim?

- ☒ Yes ☐ No

6. If you answered "Yes" to Question #5, provide the following information:

Cochran & Cochran
(Law Firm Name)

Edward W Cochran
(Attorney's First Name) (Middle Initial) (Last Name)

2872 Buxton Rd
(Street Address)

Shaker Heights OH 44120
(City) (State) (Zip Code)

216751-5546 216751-6630
(Daytime Area Code & Phone Number) (Fax Area Code & Number)

(E-mail Address, if any)

BLUE FORM - 3



[REDACTED]

b. Specify the relationship of the Derivative Claimant to the Diet Drug Recipient.

- ☐ Spouse
 ☐ Dependent, specify _____
☐ Parent
 ☐ Other relative, specify _____
☐ Child
 ☐ Significant other, specify _____

c. If you selected "Spouse" above, what is the current status of the relationship of the Derivative Claimant to the Diet Drug Recipient?

- ☐ Married
 ☐ Divorced
 ☐ Separated
 ☐ Widowed

Date of the marriage: ____/____/____
(MM/DD/YYYY)

d. If you, the Derivative Claimant, are currently estranged from the Diet Drug Recipient, state the date of separation and/or divorce.

Date: ____/____/____
(MM/DD/YYYY)

(Provide evidence of the date of separation or divorce, i.e., separation agreement or divorce decree).

e. Identify the basis on which the Derivative Claimant is claiming "derivative" benefits.

- ☐ Loss of Consortium/Per Quod (e.g., loss of marital services and relationship)
☐ Loss of Support
☐ Loss of Service
☐ Other, explain: _____

NOTE: Each Claimant (including Representative and/or Derivative Claimants) must sign the Declaration under Penalty of Perjury on page 7 of this BLUE FORM (making copies if necessary) and submit it with this form.

5. Are you represented by any lawyer in connection with this Claim?

- ☒ Yes
 ☐ No

6. If you answered "Yes" to Question #5, provide the following information:

Bishop & Associates
 (Law Firm Name)
Robert W Bishop
 (Attorney's First Name) (Middle Initial) (Last Name)
6520 Glenridge Park Suite 10
 (Street Address)
Louisville KY 40222
 (City) (State) (Zip Code)
502.425.2600 502.425.9115
 (Daytime Area Code & Phone Number) (Fax Area Code & Number)

 (E-mail Address, if any)

BLUE FORM - 3



NOTE: If you are completing this questionnaire as a Representative or Derivative Claimant, the following questions using the term "You" refer to the "Diet Drug Recipient."¹

7. State whether you were prescribed and took the following Diet Drugs:

Pondimin® (Fenfluramine) ☒ Yes ☐ No

Redux™ (Dexfenfluramine) ☐ Yes ☒ No

8. Indicate by checking the appropriate box below the total period of time that you took Pondimin® and/or Redux™:

(If you took both drugs, add together the period of time you used each drug to determine the total period of use.)

☐ 60 days or less ☒ 61 days or more

9. State the total number of days that you used each of the following diet drugs:

Pondimin® 74 days

Redux™ 0 days

You bear the ultimate responsibility for providing records to substantiate the total number of days you used Pondimin® and/or Redux™.

10. You must provide the information requested below.

a. If the diet drug (Pondimin® and/or Redux™) was dispensed by a pharmacy, identify the pharmacy name, address and telephone number.

(Pharmacy Name)

(Street Address)

(City)

(State)

(Zip Code)

() _____
(Area Code and Phone Number)

[If there was more than one pharmacy that dispensed the diet drugs Pondimin® and/or Redux™, make a copy or copies of this page and provide the information for each such pharmacy and include those additional sheets with this form.]

Provide a copy of the pharmacy prescription dispensing records (e.g., prescription printouts, pharmacy records, prescription forms) from each pharmacy, which should include the medication name, quantity, frequency, dosage and number of refills prescribed, prescribing physician's name, assigned prescription number, original fill date and each subsequent refill date.

OR

¹ The "Diet Drug Recipient" is the person who took Pondimin®, Redux™, and/or the drug combination commonly known as "Fen-Phen."



- b. If the diet drug (Pondimin® and/or Redux®) was dispensed directly by a physician or weight loss clinic, or the pharmacy record(s) is unobtainable, state the name of each physician who prescribed the diet drug, and the address and telephone number of that physician:

Peggy _____ Fishman _____
 (First Name of Prescribing Physician) (Middle Initial) (Last Name)
 Medical Weight Management _____
 (Name of Weight Loss Clinic, if applicable)
 2932 Breckenridge Ln _____
 (Street Address)
 Louisville _____ KY 40220 _____
 (City) (State) (Zip Code)
 502-451-7320 _____
 (Area Code & Telephone Number)

[This is not the original office I visited. They have moved & it is my understanding the above is the office which has my records - also see attached record]

(If there was more than one physician or weight loss clinic that prescribed and/or dispensed the diet drugs Pondimin® and/or Redux®, make a copy or copies of this page and provide the information for each such physician or weight loss clinic and include those additional sheets with this form.)

Provide a copy of the medical record(s) reflecting the prescription and/or dispensing of the diet drugs. This must include records that identify the Diet Drug Recipient, the diet drug name, the date(s) prescribed, the dosage and duration for which the drug was prescribed or dispensed.

If, and only if, the pharmacy record(s) or prescribing physician's medical record(s) are unobtainable, check here ☐ and have your prescribing physician or dispensing pharmacist complete the attached Declaration of Prescribing Physician or Dispensing Pharmacy.

11. Have you had an Echocardiogram¹ after you first started using diet drugs?

☐ Yes ☒ No

If yes, state the date(s) of each Echocardiogram(s) and the name and address of each physician who performed the Echocardiogram or reported the results to you.

Date	Name of Physician/Clinic	Address of Physician/Clinic
____/____/____ (MM/DD/YYYY)	_____	_____
____/____/____ (MM/DD/YYYY)	_____	_____
____/____/____ (MM/DD/YYYY)	_____	_____

If you are seeking benefits based on the results of this Echocardiogram(s), you must attach a copy of each Echocardiogram report and include the videotape or disk of the Echocardiogram as part of your Claim submission.

¹ An Echocardiogram is a test in which sound waves are passed through the chest to result in a video image of the heart and its valves. It should not be confused with an "electrocardiogram" in which sensors are placed at various locations on the body and a paper readout is generated.



12. If you answered "Yes" to Question #11, answer the following to the best of your knowledge:

- a. Did any show mild or greater aortic regurgitation? ☐ Yes ☐ No
 b. Did any show moderate or greater mitral regurgitation? ☐ Yes ☐ No
 c. Did any show mild mitral regurgitation? ☐ Yes ☐ No
 d. Don't know ☐

If you answered "Yes" to Questions #12.a, #12.b, or if you checked the box for #12.d, you must submit a GRAY FORM or GREEN FORM to complete your Claim.

If you answered "Yes" to Question #12.c, you should file a GRAY FORM to preserve your future rights under the Settlement Agreement. (See page 8, Item 6 for a more detailed explanation of the GRAY FORM.)

13. If you would like to receive information about the Compassionate and Humanitarian program described in the Official Notice, call 1-800-386-2070.

14. If you would like to receive information concerning reimbursement benefits for all or part of the cost of certain privately-obtained Echocardiograms, call 1-800-386-2070.

15. State whether you elect to receive cash benefits or medical services³ if you qualify for this benefit. Such benefits or services will only become available to you if the AHP Settlement Trust determines that you are eligible. To seek this benefit, you must complete, sign and mail to the AHP Settlement Trust this BLUE FORM postmarked no later than May 3, 2003. You may select only one option.

- ☐ I elect to receive \$6,000 in cash if the AHP Settlement Trust determines that I took the diet drugs Pondimin® and/or Redux™ 61 days or more, and I am diagnosed as "FDA Positive" on or before January 3, 2003, or \$3,000 in cash if the AHP Settlement Trust determines that I took the diet drugs Pondimin® and/or Redux™ for 60 days or less, and I am diagnosed as "FDA Positive" on or before January 3, 2003.

OR

- ☐ I elect to receive \$10,000 in heart valve-related medical services if the AHP Settlement Trust determines that I took the diet drugs Pondimin® and/or Redux™ 61 days or more, and I am diagnosed as "FDA Positive" on or before January 3, 2003, or \$5,000 in heart valve related medical services if the AHP Settlement Trust determines that I took the diet drugs Pondimin® and/or Redux™ for 60 days or less, and I am diagnosed as "FDA Positive" on or before January 3, 2003.

16. Do you believe that you have any medical condition which qualifies for payment on the Compensation Matrices described in the Official Notice of Final Judicial Approval?

- ☐ Yes

Note: If you answered "Yes" to the previous question, you and a Board-Certified Cardiologist and/or not Board-Certified Cardiothoracic Surgeon (and in some instances, a Board-Certified Pathologist, a Board-Certified Neurologist or Board-Certified Neurosurgeon) also must complete the separate Matrix Benefits Compensation Claim Form—the GREEN FORM—to obtain the benefit. *Not that I am aware of at this time, I have not yet had an echocardiogram & am not a doctor*

³ The medical services shall be limited to the care of Valvular Heart Disease. The Trustees may include the following services, when performed, supervised, or prescribed by a physician specializing in internal medicine, cardiology or cardiothoracic surgery: comprehensive physical examinations, chest x-rays, electrocardiograms, standard laboratory testing, medically-appropriate Echocardiograms, and/or medically-supervised nutritional counseling and/or any accepted technology or techniques for the management of valvular heart disease.



17. **Confidentiality.** By signing below, I authorize disclosure of the information contained in this form and any other documents supplied in connection with my claim to such persons as may be reasonably necessary for purposes of processing any claim and providing any benefits under the Settlement Agreement.

18. **CONDITIONAL RELEASE OF SETTLED CLAIMS AND COVENANT NOT TO SUE.** In consideration of the obligations of American Home Products Corporation ("AHP") under the Nationwide Class Action Settlement Agreement with American Home Products Corporation ("Settlement Agreement") approved by the United States District Court for the Eastern District of Pennsylvania, I, the undersigned claimant, individually and for my heirs, beneficiaries, agents, estate, executors, administrators, personal representatives, successors and assignees, and/or, if the undersigned claims as a representative of the person who used Pondimin® and/or Redux™, whether as heir, beneficiary, agent, estate, executor, administrator, personal representative, successor, assignee, guardian, or otherwise, and in that capacity, or, if applicable, the undersigned as a person who has a Derivative Claim under the Settlement Agreement, and in that capacity, hereby expressly release and forever discharge, and agree not to sue, AHP and all other Released Parties (as defined in the Settlement Agreement) as to all Settled Claims (as defined in the Settlement Agreement), asserted against AHP or any Released Party. The Settlement Agreement, including, without limitation its benefit and its release provisions, and the definitions of the terms "Settled Claims" and "Released Parties," is incorporated by reference as if fully set out at length. I further agree to the provisions of the Settlement Agreement concerning "Judgment Reduction for Claims by Third Parties" which are summarized in the Notice of Settlement. For purposes of this Conditional Release of Settled Claims and Covenant not to Sue, the terms "Settled Claims" and "Released Parties" are defined as set forth in the Settlement Agreement and in the Notice of Settlement. I understand that certain principles of law, such as those reflected in statutes like Section 1542 of the California Civil Code and in the common law of many states, provide that a release may not extend to claims which the undersigned does not know or suspect to exist. I am aware that I may discover claims presently unknown or unsuspected, or facts in addition to or different from those which I now believe to be true with respect to the matters released herein which may be applicable to this settlement. Nevertheless, I hereby knowingly and voluntarily relinquish the protections of Section 1542 and all similar federal or state laws, rights, rules or legal principles that may be applicable. In the event that the undersigned properly exercises any Intermediate or Back-End Opt-Out rights under the Settlement Agreement, then this conditional release shall be null and void and of no further force and effect except to the extent provided in Section IV.D of the Settlement Agreement. I, THE UNDERSIGNED, HAVE CAREFULLY READ (OR HAVE HAD READ TO ME) THIS CONDITIONAL RELEASE OF SETTLED CLAIMS AND COVENANT NOT TO SUE. I, THE UNDERSIGNED, UNDERSTAND THE TERMS OF IT, AND AGREE TO BE BOUND BY IT.

19. **Declaration under Penalty of Perjury.** Each person signing below acknowledges and understands that this form is an official Court document sanctioned by the Court that presides over the Diet Drug Settlement, and submitting it to the AHP Settlement Trust is equivalent to filing it with a Court. Each agrees to cooperate with the AHP Settlement Trust and to provide any necessary medical record authorization and releases for the AHP Settlement Trust to gather information needed to substantiate or audit the Claim. Each declares under penalty of perjury that the information provided in this form is true and correct to the best of his/her knowledge, information and belief.

Angela J. Duffy
(Signature of Diet Drug Recipient, if living)

Date: 07/29/2002
(MM/DD/YYYY)

(Signature(s) of Legal Representative(s) of Diet Drug Recipient, if any)

Date: ____/____/_____
(MM/DD/YYYY)

(Signature(s) of Claiming Spouse, Parent, Child, Dependent, Other Relative, or "Significant Other," if any)

Date: ____/____/_____
(MM/DD/YYYY)

(NOTE—Copy this page if you need room for additional signatures, and include copied and signed pages with this form.)

BLUE FORM - 7





REMEMBER: *To complete your Claim, you must supply the following to the AHP Settlement Trust:*

1. Written proof of the amount of Pondimin® and/or Redux™ which was dispensed for your use by your drugstore(s), pharmacy(ies), doctor(s), clinic(s) or health care facility(ies).
2. If you are submitting this form as a Representative Claimant, a copy of the order or other document appointing you as the Diet Drug Recipient's legal representative.
3. If you are representing a deceased's estate, a copy of the death certificate, along with a copy of any letters of administration or probate or surrogate certificate.
4. A signed Authorization for the Release of Medical Records included in this form.
5. If you are seeking benefits based on the results of an Echocardiogram(s) that you identified in Question #11, you must supply a copy of each Echocardiogram report and the videotape or disk of each.
6. A GRAY FORM if you are claiming Benefits based upon an Echocardiogram performed after September 30, 1999.
The GRAY FORM must be accompanied by the report of the results of the Echocardiogram and a copy of the Echocardiogram tape or disk.
7. If you claim Matrix Compensation Benefits, you and your doctor must complete the Matrix Compensation Benefits Claim Form—the GREEN FORM—and mail it to:

**AHP Settlement Trust
P.O. Box 7939
Philadelphia, PA 19101**

If you change your address, you must promptly notify the AHP Settlement Trust in writing of your new address.

For assistance call 1-800-386-2070, or access the AHP Settlement Trust's website at <http://www.settlementdietdrugs.com>.

BLUE FORM - 8



EXHIBIT “9”

Claim Inquiry: RHEA, DEBRA K - DDR # 2018398

DDR #	DDR Name	PIN	SSN	DoB	Admin Hold
2018398	RHEA, DEBRA K 2413 CHATTESWORTH LANE LOUISVILLE, KY 402422850	48839 Day Phone: NightPhone:	405-84-5062 (502) 423-9687 (502) 423-9687	10/20/1955	

Attorney Information:

Type	Attorney	Firm	City	State
------	----------	------	------	-------

Claim Payments

Type	Check #	Date	Amount	Status	Clear Date
GRAY2	2009194	9/13/2002	\$727.27		9/18/2002
CMS	2037716	11/20/2002	\$6,000.00		11/10/2003
DRUG	2424898	11/10/2003	\$395.00		6/10/2004

General Deficiencies:

Code	Deficiency	Def Date	Cancel Date	Notice Date	Strikes
------	------------	----------	-------------	-------------	---------

Green Deficiencies:

Def Date	Cancel Date	Notice Date	Strikes
----------	-------------	-------------	---------

Green Form Data

Physician	Phys City	State	GF Mx	GFA Mx	Audit Mx	Res
-----------	-----------	-------	-------	--------	----------	-----

Gray Data

Status	Physician	Echo Date	MR	AR	
A	MUKUL CHANDRA MD	8/7/2002	Mild	Moderate	2

Document History

Doc Code	Document Type	Rec Date	Post Mark	Box #	DCN
59	TAPE COPY REQUEST	12/2/2002	11/26/2002		14325912018398
16	GRAY #2	8/22/2002		3463	13301612018398
02	BLUE	4/3/2000			00094020046034

Claim Activities:

Activity		Date	Cancel Date
PY_DRUG	BENEFIT PAID -- DRUG	11/10/2003	
SB_DRUG	SCHEDULED FOR BENEFIT -- DRUG	11/4/2003	11/10/2003
WY_DRUG	CLAIM AT WYETH ACCESS -- DRUG	10/10/2003	11/4/2003
WR_DRUG	READY FOR WYETH ACCESS -- DRUG	10/7/2003	10/10/2003
QA_CMS	SCHEDULED FOR CMS QA REVIEW	10/3/2003	
QA_DRUG	SCHEDULED FOR DRUG QA REVIEW	10/3/2003	10/7/2003
RV_ECHO	SCHEDULED FOR ECHO REVIEW	10/3/2003	
QA_ECHO	SCHEDULED FOR ECHO QA REVIEW	10/3/2003	
RV_CMS	SCHEDULED FOR CMS REVIEW	10/3/2003	
TCPREQ	REQUEST FOR TAPE COPY	12/25/2002	
SB_CMS	SCHEDULED FOR BENEFIT -- CMS	11/20/2002	11/20/2002
PY_CMS	BENEFIT PAID -- CMS	11/20/2002	
WR_CMS	READY FOR WYETH ACCESS -- CMS	11/8/2002	11/20/2002
RV_CMS	SCHEDULED FOR CMS REVIEW	11/6/2002	11/8/2002
QA_CMS	SCHEDULED FOR CMS QA REVIEW	11/6/2002	11/8/2002
WR_CMS	READY FOR WYETH ACCESS -- CMS	10/30/2002	10/30/2002
WY_CMS	CLAIM AT WYETH ACCESS -- CMS	10/30/2002	11/20/2002
RV_CMS	SCHEDULED FOR CMS REVIEW	10/24/2002	10/30/2002
QA_CMS	SCHEDULED FOR CMS QA REVIEW	10/24/2002	10/30/2002
SPNMLD	Screening program notice mailed	9/24/2002	
PY_GRAY2	BENEFIT PAID -- GRAY2	9/13/2002	
SB_GRAY2	SCHEDULED FOR BENEFIT -- GRAY2	9/12/2002	9/13/2002

Friday, December 03, 2004

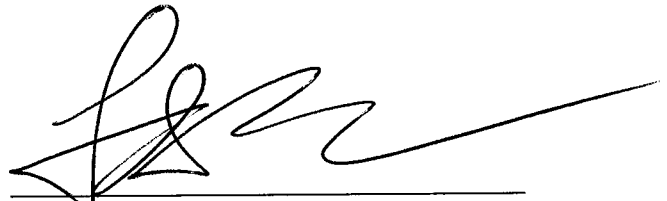
Privileged And Confidential

Page 1 of 2

ESCR_APT	ECHO Screening Appointment Made	8/7/2002	
CCN_LTR	CCN Matching letter sent	5/9/2002	
PY_ESCR	SENT TO CRAWFORD FOR ECHO	1/25/2002	
RV_DRUG	SCHEDULED FOR DRUG REVIEW	1/25/2002	10/7/2003
SB_ESCR	SCHEDULED FOR BENEFIT -- ECHO	1/24/2002	1/25/2002
WR_ESCR	READY FOR WYETH ACCESS -- ESCR	1/16/2002	1/24/2002
WY_ESCR	CLAIM AT WYETH ACCESS -- ECHO	1/16/2002	1/24/2002
LBL	Sent Blue Only letter	1/6/2002	
LACKA	Acknowledgement Ltr - Auto	7/17/2000	7/17/2000

CERTIFICATE OF SERVICE

I, Laurence S. Berman, Esquire, do hereby certify that a true and correct copy of Supplement to Class Counsel's Motion: (A) to Strike the Seventh Amendment Objections of Angela Duffy, Frank DeJulius and Cindy Pattison for Lack of Standing and (B) for Leave to Take Depositions of Seventh Amendment Objector, Debra Rhea has been served on this 5th day of December, 2004 via United States Postal Service, postage pre-paid to the persons on the attached Service List on this date.



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